Nevada State Health System
Innovation Plan

State Innovation Model

January 29, 2016

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I. EXECUTIVE SUMMARY

Background

The state of Nevada is committed to making meaningful and sustainable changes to its health care delivery and payment systems in alignment with the triple aim of improved population health, better care and greater value for health care spending. The state undertakes this effort with the primary goal of improving the health status of its citizens. This commitment extends beyond state-funded programs and the individuals served through those programs to all Nevadans. To facilitate the development of a plan to achieve this future state, Nevada received a $2 million Round Two State Innovation Model (SIM) design grant through the Center for Medicare and Medicaid Innovation (CMMI) on December 16, 2014.

Nevada's award supported the development of a statewide, multi-payer, stakeholder informed State Health System Innovation Plan (SHSIP). The resulting SHSIP is designed to provide a multiyear road map for sustainable transformation. This road map is Nevada specific and seeks to leverage and supplement existing initiatives where feasible and where value can be obtained. The SHSIP will guide the implementation of priority interventions identified by stakeholders that best address the needs and constraints identified within the Nevada health care delivery and payment system. As Nevada's health care landscape evolves over time, the plan will need to be reassessed and modified to meet current and future needs.

Through the SIM funding opportunity, CMMI recognized the power of the state as an integrator and facilitator of statewide transformation. In this role, Nevada executed an extensive stakeholder engagement process that will continue in various forms through the implementation and evaluation of the SHSIP. Through this process, the Nevada Department of Health and Human Services' (DHHS) Division of Health Care Financing and Policy (DHCFP) formed and received input from workgroups, taskforces, the Nevada SIM Core Team, an Executive Committee and a Multi-Payer Collaborative (MPC). Broader stakeholder engagement was accomplished through a series of kickoff meetings, community meetings held throughout the state and stakeholder update meetings.

Consistent with the triple aim objective, the transformation envisioned by Nevada and detailed in the SHSIP seeks to reward health care providers for quality, instead of quantity of services by instituting alternative payment methodologies through value-based purchasing (VBP) across public and private payers. The MPC collectively brings an enrollment of more than 700,000 Nevadans or approximately 25 percent of the state's population to this initiative. This collaborative currently includes Medicaid, the Children's Health Insurance Program (CHIP) (also known as Nevada Check Up), the Nevada Public Employees' Benefit Program (PEBP), Indian Health Services (IHS) and the Culinary Health Fund (CHF). The MPC will initiate the SHSIP with the intent of attracting other payers over time so that all payers are committed to a consistent vision for the improved health of the state's population by the end of 2021.

Mission Statement

The overarching mission statement developed by Nevada to guide the Nevada SIM project is to increase health care value while improving outcomes, access and containing health care expenditures in Nevada.

Vision

Nevada has developed four overarching goals that will guide the implementation of the SHSIP:

- Redesign the state's health care delivery system to contain health care costs while increasing health care value
- Establish reliable and consistent access to primary and behavioral health care services
- Improve quality and health outcomes for all Nevadans
- Foster greater Health Information Technology (HIT) and health data infrastructure adoption, exchange and utilization

Health Care Delivery System and Payment Transformation

Redesigning Nevada's health care delivery system will require the collaborative efforts of multiple payers. While the SHSIP utilizes the state policy authority and reach of the Medicaid agency as a cornerstone for reform, transformation must be wide-reaching and pervasive across all payers. All payers must strive to achieve transformation without creating undue burdens for providers and citizens. The success of the transformation will be reliant on the recognition that care is most impacted during the interaction between a provider and an individual, and the engagement of both is critical to success. Providers must be able to transition to the new delivery and payment system with administrative ease. In addition, maximum provider support and transparency from payers needs to be established.

To achieve the Nevada aims, the provider payment methodologies must be reengineered. In today's environment, providers are paid almost exclusively on a fee-for-service (FFS) basis, which incentivizes providers to increase the volume of services to maximize financial gains. Through the implementation of the SHSIP, Nevada will move from this volume-based reimbursement model to a model that pays for value and outcomes. Providers will practice medicine in an environment where payment is based not on the quantity of services rendered but on the quality of those services provided, outcomes achieved and wellness of their attributed patients.

Nevada's health care delivery and payment transformation will be initiated through the development and implementation of three foundational program initiatives: Patient-Centered Medical Homes (PCMHs), Medicaid Health Homes (MHHs) and the super-utilizer program. A PCMH program will be designed to ensure better coordination of care, improved patient-provider relationships and engagement, greater health outcomes and patient experience, and more appropriate health care expenditures. DHCFP also will implement an MHH

program that will build upon the PCMH model and create an enhanced level of coordination and intervention for certain Medicaid members with complex conditions and needs. A super-utilizer program across all participating payers also will be developed to address the unmet needs of individuals with high utilization and poorly managed health patterns.

Access to Physical and Behavioral Health Services

The combined impact of the rural and frontier nature of much of the state, along with a workforce shortage of not only physicians but other health care professionals, calls for infrastructure to provide reliable and consistent access to physical and behavioral health care services. Nevada will:

- Promote appropriate utilization and reimbursement options for telemedicine
- Deploy paramedicine services during certain critical transitions in care settings
- Ensure health care professionals are permitted to practice at the highest level of their training and scope of practice
- Support the expansion of Project ECHO in supplying primary care physicians (PCPs) with access to specialty consultations and expertise
- Utilize Community Health Workers (CHWs) to meet individuals where they are and assist with their navigation through the health care delivery system
- Promote opportunities to improve the size of the Nevada health care workforce

Improve Quality and Health Outcomes

Based on the predominant health care conditions, the state emphasizes early intervention and prevention, and desires to ensure that the needs of Nevada's youth are addressed. Through the implementation of the SHSIP, Nevada seeks to:

- Improve prevention and early intervention efforts
- Improve tobacco cessation rates
- Strengthen behavioral health outcomes
- Reduce the prevalence and incidence of obesity, diabetes and cardiovascular disease
- Ensure more appropriate Emergency Department (ED) utilization behaviors

These efforts will leverage existing programs and interventions within the state, where possible.

Health Information Technology (HIT) Infrastructure, Data Exchange and Utilization

The success of the SHSIP will depend on the ability to leverage the existing HIT infrastructure and expand its role in the exchange and availability of patient health information at critical points in the health care delivery process. Provider adoption and utilization of HIT and the data it provides will be critical. The SHSIP envisions:

- Improved adoption and use of a statewide Health Information Exchange (HIE)
- Development of an All Payer Claims Data Repository (APCDR)
- Leveraging relevant public health registries
- Procurement of a robust population health management tool, which will include a role-based portal for providers, patients and the public
- Provision of technical assistance to providers

Summary

Nevada seeks to improve the health status and care received by its citizens as well as value received for its health care expenditures. Significant and sustainable improvements in these areas will require changes to how health care is accessed, delivered and reimbursed; how outcomes are achieved and measured; and how HIT is leveraged to support all aspects of these goals. Furthermore, these improvements depend on payers working collaboratively to ensure a common voice and avoidance of administrative burdens for providers and citizens.

II. ORGANIZATION OF THE SHSIP

A description of the organization of the SHSIP and its purpose are offered here to aid readers in reviewing the plan.

Project Approach
This section provides insight into Nevada's approach to the SIM project. This includes: project oversight and governance, stakeholder engagement, multi-payer involvement, and leveraging existing initiatives and resources. The inclusive nature of the project, with strong stakeholder engagement and committed leadership, formed a strong foundation to support the implementation of the SHSIP.

Current Nevada Environment
This section describes the state demographics and the diversity of the Nevada citizens. Descriptions of the current health care delivery system and health care workforce are presented to identify how care is delivered and accessed today. The most pressing health care issues are also discussed.

HIT Plan
A critical component of the Nevada SHSIP is the need to improve the state's HIT infrastructure and promote the meaningful adoption and use of HIT. The HIT Plan charts a course for the state that envisions improved access to health information for providers, citizens and the public. Providers will benefit from a more robust statewide HIE with a greater percentage of Nevadans' health care data being contributed and exchanged across providers. The availability of this information at the point of care and during care coordination activities is anticipated to result in less duplication of services, fewer unnecessary expenditures and better outcomes.

Delivery System Transformation
This section introduces the key elements Nevada seeks to achieve through the SHSIP, as a result of the strong stakeholder engagement process and extensive research and analysis. Each of these efforts leads to improving the health care delivery system, achieving payment reform, improving population health and developing Nevada's HIT infrastructure and adoption. The discussion of these components mirrors the driver diagram (*Section VI*). The driver diagram guides the reader through the overall aims, the primary drivers and secondary drivers ultimately supporting these aims. Operational metrics that will be used to assess progress are presented in the expanded driver diagram (*Attachment F*). Due to the difficulty of implementing all of these activities with limited financial resources and human capital, the complexity and contemplated timeline for implementation of each activity are also presented.

Payment Transformation
Through the implementation of this plan, Nevada will move from a health care delivery system that pays for volume of services to one that recognizes value and outcomes. A planned approach that evolves over time from incentives, shared savings, bundled payments, alternative payment models and possible shared risk models is discussed. This

section reiterates that the accountability for fiscal and clinical outcomes under this new model is dependent upon the maximization of HIT to provide useful and timely information at the point of care.

Population Health Plan

With an understanding of the state demographics and disparities, the current health care delivery and payment system and the desired transformational components under the SHSIP, this section relates each of those transformational elements to their contribution to improved population health. Descriptions of the envisioned impact on population health by disease state or condition along with the metrics that will be used to assess population health improvement are presented here.

Workforce Development Plan

This section of the plan acknowledges the rural and frontier areas of the state and the inherent access issues that exist as a result. A discussion of opportunities to address and mitigate these issues is presented.

Operational Plan

The three essential components of the Operational Plan are: implementation, sustainability and monitoring. The discussion on implementation offers a logical approach to implementing the components in a phased-in approach. The actual implementation schedule will be dependent upon the availability of financial and human capital resources, and implementation of aspects of the plan that have lower complexity but higher return on investment (ROI) have been prioritized for earlier implementation.

Sustainability includes both fiscal and operational components. The fiscal sustainability plan in which savings achieved during the early implementation phases will be used as investments to move the plan forward and implement the next priorities is discussed. This section also presents the operational sustainability and need for ongoing investment in human capital to support the SHSIP and includes the recommended staffing investment and staffing's roles in the SHSIP.

Implementation of the plan must be accompanied by a plan to monitor that implementation. The approach to monitoring the performance of the initiatives implemented under the plan is discussed here, including the need for rapid cycle improvement and the formation of learning collaboratives. The challenging effort of isolating the impact of the plan versus other variables that may be contributing to the observed results also is discussed.

To assist SHSIP readers, a summary of relevant Nevada health care waivers and grants has been outlined in *Attachment A*. In addition, a glossary of terms found in the SHSIP is provided in *Attachment B*.

III. PROJECT APPROACH

The CMMI Round Two SIM Model Design funding opportunity provided the Nevada DHHS with $2 million to develop a SHSIP. The DHHS is the largest department in state government, comprised of six divisions along with additional programs and offices overseen by the DHHS's Director's Office. These Divisions include: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy, Public and Behavioral Health, Welfare and Supportive Services, and Public Defender. The Department's DHCFP was tasked with responsibility for this funding opportunity and the development of the SHSIP.

Nevada's project approach included strong project governance and oversight as well as robust stakeholder and payer engagement in the entire SHSIP development process.

A. Oversight and Governance

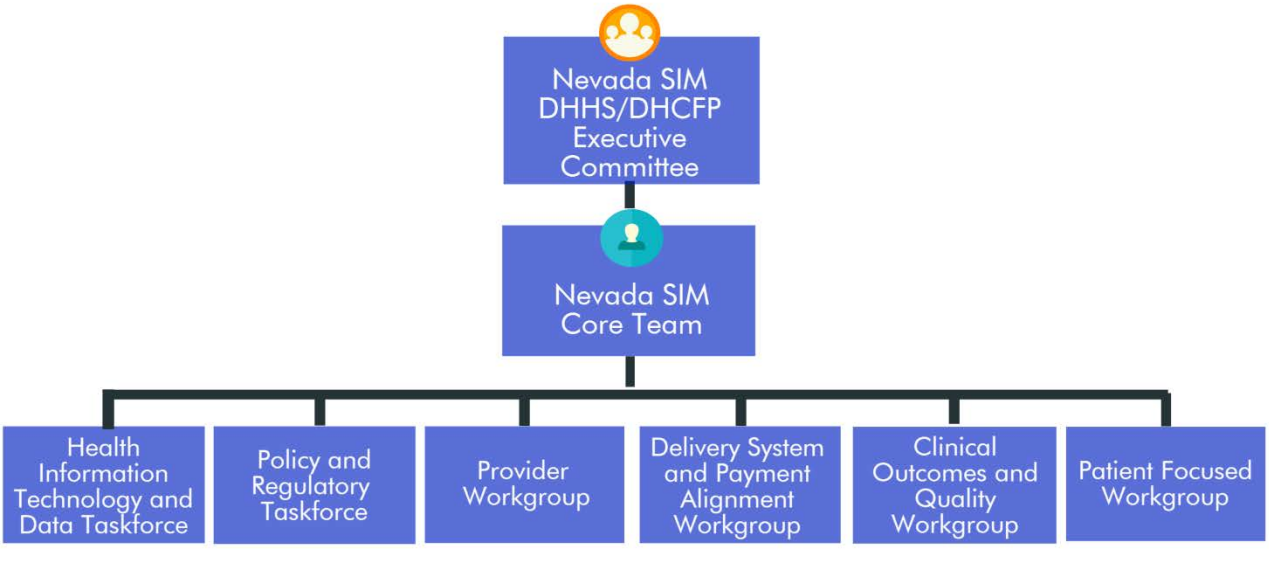
Upon project initiation, the DHCFP assumed responsibility for conducting all activities related to this project. DHCFP formulated a Nevada SIM Core Team composed of state staff and supported by Myers and Stauffer LC. The Nevada SIM Core Team reports to an Executive Committee composed of key leadership from the DHHS. The Executive Committee, which met throughout the project, provided strategic oversight and direction to the Nevada SIM Core Team. This committee will continue to provide the executive sponsorship and ultimate decision-making authority throughout the SHSIP implementation. *Figures 1* and *2* illustrate the Nevada SIM Executive Committee and SIM Core Team membership, titles and the role of each group.

Figure 1: Nevada SIM Executive Committee and Core Team

Nevada SIM Executive Committee	
Role: The Nevada SIM Executive Committee served as the sponsoring committee for the SIM project and provided executive leadership. Routine reports of progress, issues, opportunities and points for executive decision-making were escalated to this committee.	
Name	**Title**
Richard Whitley	DHHS, Director
Tracey Green, M.D.	DHHS, Chief Medical Officer
Dena Schmidt	DHHS, Deputy Director for Programs
Marta Jensen	DHCFP Acting Administrator

Nevada SIM Core Team	
Role: The Nevada SIM Core Team had direct responsibility to conduct all activities necessary to achieve the purpose of the SIM Model Design project.	
Name	**Title**
Janice Prentice	SIM Project Team Manager, Chief, Rates and Cost Containment, DHCFP
Debra Sisco	SIM Project Team Lead, Supervisor, Rates and Cost Containment, DHCFP
Chani Overli	SIM Grant Analyst, DHCFP
Keturah Stanford	SIM Project Support, Administrative Assistant, Rates and Cost Containment, DHCFP
Rebecca Vernon-Ritter	Management Analyst III, Rates and Cost Containment, DHCFP
Myers and Stauffer LC	Consultant

Figure 2: Nevada SIM Oversight Structure



B. Stakeholder Engagement and Design Process Deliberations

In support of this project and to ensure broad stakeholder input contributed to the development of the SHSIP, a Stakeholder Engagement Plan was designed and implemented. DHCFP adopted a philosophy that public outreach and involvement fosters active participation and an open decision-making process from the community. This Stakeholder Engagement Plan included a proactive approach for public involvement and the application of robust and innovative outreach and engagement methods. Given the rural nature of much of the state, an awareness of the rural versus urban environments was considered in the stakeholder engagement process. The goal of the Stakeholder Engagement Plan was to identify and evaluate suggestions, comments, concerns and the unique needs of stakeholders as they relate to the transformation effort.

The primary mechanisms for stakeholder engagement are described below:

- ***Outreach:*** Outreach tools were used to raise awareness, engage people and publicize education and engagement opportunities through verbal communications, email/written communications and website publications. The project used public meetings, webinars, direct contact with key stakeholders and inclusion of SIM related topics in public speaking opportunities.
- ***Education:*** Education tools were used to inform people about the program and provide facts that assist policy makers in making informed decisions regarding health care. The project educated individuals about the programs and support available through websites, e-newsletters/e-blasts, fact sheets, frequently asked questions (FAQs) and webinars.
- ***Engagement:*** Engagement tools work to foster an environment that opens dialogue with stakeholders. This process focuses on influencing both short- and long-term policy, implementation and process measures. The project utilized interviews, briefings, workgroup and taskforce meetings, focus groups, a Web-based survey, interactive community meetings, and other forms of active communication.

Listed below are summaries of stakeholder engagement activities performed during the Nevada SIM Model Design process and the respective participants.

Kickoff Meetings

Internal Kickoff Meeting

DHCFP held an internal kickoff meeting on February 11, 2015, in Carson City, Nevada. The purpose of this meeting was to ensure a common understanding among state staff regarding the SIM Model Design grant objectives, and the opportunity to leverage existing projects and programs while eliminating duplication of efforts. The process for stakeholder input and engagement and the expectations of the internal stakeholders throughout the SIM initiative were discussed.

The internal kickoff meeting included invitations to:

- Representatives from the Nevada DHHS, including:
  - The Aging and Disability Services Division (ADSD), which represents Nevada's elderly, children and adults with disabilities or special health care needs
  - The Division of Child and Family Services (DCFS), together in partnership with families, communities and other governmental agencies, which provides support and services to assist Nevada's children and families in reaching their full potential
  - The DHCFP, which works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality health care for eligible individuals and families with low incomes and limited resources through the administration of two major federal health coverage programs: Medicaid and Nevada Check Up
  - The Division of Welfare and Supportive Services (DWSS), which provides high quality, timely and temporary services, enabling Nevada families, the disabled and elderly to achieve their highest levels of self-sufficiency. Programs administered are Child Care, Energy Assistance, Food (SNAP) and Financial Assistance (TANF). The DWSS also processes eligibility applications for the state's health care programs.
  - The Division of Public and Behavioral Health (DPBH), which has a mission to protect, promote and improve the physical and behavioral health of Nevadans
- The Center for Health Information Analysis (CHIA) for Nevada is a research center at the University of Nevada Las Vegas (UNLV) within the School of Community Health Sciences. CHIA is contracted by the DHCFP.
- The two managed care organizations (MCOs) contracted to serve Nevada's Medicaid population
- Representatives from Governor Brian Sandoval's Office

External Kickoff Meetings

Two external kickoff meetings for the grant were held in March 2015. The first meeting was held in Las Vegas on March 10, 2015, and the second meeting was held March 11, 2015, in Carson City, Nevada. Each of the external kickoff meetings was conducted using Adobe Connect to allow interested parties who could not be physically present to join through the Web. Attendees of the external kickoff meetings included state and local government agencies, other payers, providers, local health officials, tribal representatives, community based organizations, health policy experts, provider industry associations, medical schools and other academic institutions, and consumer advocates, among others. Public notice was published advising the public of this forum and promoting awareness. These interactive meetings provided an opportunity for stakeholders to actively engage with the DHCFP

regarding their perspectives on the directions that should be taken on the SIM opportunity. The objectives of the external kickoff meeting were to:

- Provide the audience with information about the SIM grant purpose and objective, as well as the Nevada-specific award
- Differentiate between the SIM Model Design and SIM Model Testing grants
- Ensure stakeholders were aware of what to expect, opportunities for input and updates, and next steps
- Identify stakeholder resources to serve on workgroups and taskforces that the DHCFP may formulate through the development of the SHSIP
- Solicit feedback and involvement from the stakeholder community

Community Meetings

Eight community meetings—both rural and urban—were held throughout the state. The purpose of the community meetings was to conduct outreach regarding Nevada's SIM grant to stakeholders and request their active participation in the planned taskforces or work groups. Awareness of these meetings was communicated through the DHCFP website and outbound calls to community coalitions and large health systems. In these meetings, the attendees had the opportunity to learn about the Nevada SIM project, ask questions and offer their thoughts on issues and opportunities related to the SIM initiative. The facilitators actively engaged audience members on topics related to Nevada's population health, citizen experience, and the health care delivery and payment system. In each meeting, attendees were invited to participate in the SIM taskforces or workgroups. The specifics of the meetings are outlined in *Figure 3.*

Figure 3: Community Meetings

Community Meetings		
Date	**City**	**Location**
4/1/2015	Las Vegas	Public Utilities Commission
4/2/2015	Tonopah	Tonopah Convention Center
4/3/2015	Caliente	Caliente Olson Senior Center
4/8/2015	Hawthorne	Mt. Grant General Hospital
4/9/2015	Ely	William Bee Ririe Hospital
4/10/2015	Winnemucca	Humboldt General Hospital
5/5/2015	Reno	Washoe County Emergency Management Center
5/6/2015	Carson City	Public Utilities Commission

Workgroups and Taskforces

Stakeholder workgroup meetings were held to solicit input, comments and recommendations from a diverse group of parties from geographically diverse areas of the state. The workgroup meetings were structured to include stakeholders with common objectives. As such, each group deliberated specific topics and evaluated issues at deeper

levels and with greater specificity. While sharing common objectives, these stakeholders did represent a cross-section of the stakeholder community, which included providers, payers, academicians and advocates. DHCFP established the stakeholder workgroups with individuals, organizations and groups known to the Division, as well as those recruited or who volunteered during the stakeholder identification process.

Four stakeholder workgroups were formed:

- Provider Workgroup
- Delivery System and Payment Alignment Workgroup
- Clinical Outcomes and Quality Workgroup
- Patient Focused Workgroup

These workgroups, along with two taskforces, shaped the primary and secondary drivers found in *Attachment F* that are needed to transform the Nevada health care delivery and payment system.

Two taskforces were formed to address overarching areas that were important to all workgroups, as well as to the project in general:

- HIT and Data Taskforce
- Policy and Regulatory Taskforce

These taskforces were convened throughout the planning period to review and evaluate questions, models and needs from each of the workgroups. The taskforces sought to answer questions such as:

- What data are needed to initiate, maintain and evaluate the proposed change?
- Are the data available and what analytic tools will be utilized?
- How will transparency into the SIM project be accomplished?
- What is the impact of the proposed effort on payer policies?
- What policies or regulations may need to be changed to support an effort and is that the best policy for the payer?
- How can the proposed effort be accomplished within the existing policy and regulatory framework?

Workgroups and taskforces met beginning the first week of May 2015 and continued to meet periodically through September 2015. Each meeting was scheduled for approximately two hours in duration. Members of the workgroups were encouraged to attend workgroup meetings in person, but accommodations using teleconference or video conferencing technology were used when available and necessary.

Membership on a workgroup or taskforce was achieved through appointment by DHCFP. In addition to its known stakeholders, DHCFP provided an opportunity for all interested parties to volunteer to serve. Individuals had an opportunity to make their interest in volunteering known at the external stakeholder meetings, community meetings, through email to the SIM project, via response to the stakeholders' electronic survey, or via direct contact with the DHCFP. A listing of workgroup and taskforce participants is included in *Attachment C.*

The general purpose and mission of each workgroup and taskforce is summarized in *Figure 4.* These workgroups and taskforces are envisioned to continue to serve as an advisory body to the DHCFP and may be convened periodically during the implementation and evaluation of the SHSIP.

Figure 4: Taskforce and Workgroup Areas for Discussion

Taskforce and Workgroup	Areas of Discussion	Meeting Dates
Health Information Technology and Data Taskforce	• Data sources, availability and standardization • Maximization of HIE and HIT resources • Population health analytics tool • Transformation support through use of HIT	April 7, 2015 May 7, 2015 June 4, 2015 July 27, 2015 September 28, 2015
Policy and Regulatory Taskforce	• Evaluation of the impact of current or envisioned policies and regulations • Policy or regulatory barriers and opportunities • Policy alignment with innovation plan components	May 5, 2015 June 3, 2015 June 24, 2015 July 28, 2015 September 28 2015
Provider Workgroup	• Provider workforce capacity • Strategies to improve access • Alternatives to traditional access and care modalities • Health disparities • Adoption and use of HIT and HIE • Value-based payments	May 7, 2015 June 4, 2015 June 24, 2015 July 27, 2015 September 28, 2015
Delivery System and Payment Alignment Workgroup	• Alternative health care delivery system models • Provider accountability for health outcomes of attributed patients • Integration of behavioral health and physical health • Tools to be successful under alternative delivery system models • Value-based payments • Urban, rural and frontier considerations	May 6, 2015 June 3, 2015 June 24, 2015 July 27,2015 September 28, 2015
Clinical Outcomes and Quality Workgroup	• Define the population health objectives • Identify clinical focus areas and priorities • Explore multi-payer considerations • Identify clinical outcome measures • Identify measures and methodologies to assess outcomes	May 6, 2015 June 4, 2015 June 24, 2015 July 27, 2015 September 28, 2015
Patient Focused Workgroup	• Patient experience with the health care system • Urban versus rural or frontier setting challenges • Social determinants impacting health • Unmet patient needs • Health literacy, patient engagement and shared decision-making	May 5, 2015 June 4, 2015 June 24, 2015 July 28, 2015 September 28, 2015

Stakeholder Participation and Charter Agreement

Workgroup and taskforce participants were required to sign a charter. The Project Charter (see sample charter in *Attachment D*) served several purposes:

- Identified the goals and anticipated activities of the workgroups and taskforces formulated to assist DHCFP with designing the SIM SHSIP
- Established the roles, responsibilities and expectations of the participants who are participating on behalf of and with the executive support of their organization
- Upon signoff, provided authorization of the participant to participate in the workgroups or taskforces
- Served as the point of reference for documentation and work product of the workgroups or taskforces
- Established agreement of the deliverables between DHCFP and the workgroup or taskforce members

The participants provided input into the Nevada SIM Model Design project based on their own experiences with the Nevada health care delivery system. The workgroups and taskforces focused on input that will achieve the triple aim and align with Governor Sandoval's seven core health care priorities.

Figure 5: Nevada's Seven Core Health Care Priorities

Public Speaking Engagements

The DHCFP staff leveraged existing public speaking engagements to educate organizations, agencies and other stakeholder groups about the SIM grant, grant activities and progress of the project. This was intended to engage unique constituencies in formats that are familiar to them. Through these public speaking engagements, additional participants in the workgroups and taskforces were solicited and additional perspectives obtained that were beneficial in developing the SHSIP.

Focused Meetings

A number of focused meetings were held with a wide array of participants. These meetings included existing Nevada programs, other states, CMMI technical assistance vendors (State Health Access Data Assistance Center [SHADAC], National Opinion Research Center [NORC] at the University of Chicago, Center for Health Care Strategies [CHCS] and the Centers for Disease Control and Prevention [CDC]), industry organizations, payers and academicians. Other state agencies and divisions also were included in the stakeholder engagement process. In addition to involvement from the Governor's Office, the Department of Business and Industry's Division of Insurance, Division of Aging Services, Division of Welfare and Supportive Services, and Department of Education participated in the discussions.

Nevada DHHS' DPBH devoted significant time to the SIM Model Design, reviewing programs and efforts that were already operational. Information the DPBH shared about their programs, successes, barriers, needs and opportunities was used to leverage the DPBH resources with the SIM initiatives. This collaboration included areas related to tobacco cessation, cardiovascular health, suicide prevention, behavioral health, obesity, diabetes prevention and control, Maternal Child Health (MCH) and dental care.

Nevada PEBP, IHS, Amerigroup, Anthem, CHF and United HealthCare/Health Plan of Nevada, most of whom provided support in the Nevada SIM Model Design application also participated in the development of the SHSIP. These stakeholders discussed programs and practices each has currently in place that can be leveraged to advance the triple aim objective.

Website

Stakeholder engagement also was supported by a Nevada SIM webpage, (http://dhcfp.nv.gov/Resources/Rates/SIMMain/). The website was designed to educate users on the SIM grant, including opportunities for involvement. The website includes FAQs, a link to an electronic survey, a calendar of events, meeting minutes, webinars about the project, contact names and email contacts.

Electronic Stakeholder Survey

The DHCFP developed an electronic survey tool that resided on the DHCFP website (https://www.surveymonkey.com/s/NV_SIM). This survey tool was an additional avenue to collect stakeholder feedback that was used throughout the project (*Attachment E*). The tool also collected demographic information, interest in receiving ongoing communications about

the SIM project and identified potential participants in workgroups and taskforces. The survey consisted of 27 questions:

- Nine questions pertained to basic demographics that included respondents' information, the location of the respondents (urban or rural) and in what area of health care the respondents are employed.
- Three questions inquired if the respondents were interested in participating in a focus group and if they desired to receive future correspondence regarding the SIM grant.
- Eight questions were devoted to ideas the respondents had regarding new or innovative health care reform programs that could potentially be used as part of the planning of the SHSIP. Questions were included to determine if the respondents were already involved in any pertinent innovative initiatives.
- The remaining seven questions were used to assess what features or areas of interest the respondents thought the SIM grant should address and the ranking of those initiatives.

An "Innovative Care Comment" form also was posted on the Nevada DHCFP website for those who preferred to complete a paper form.

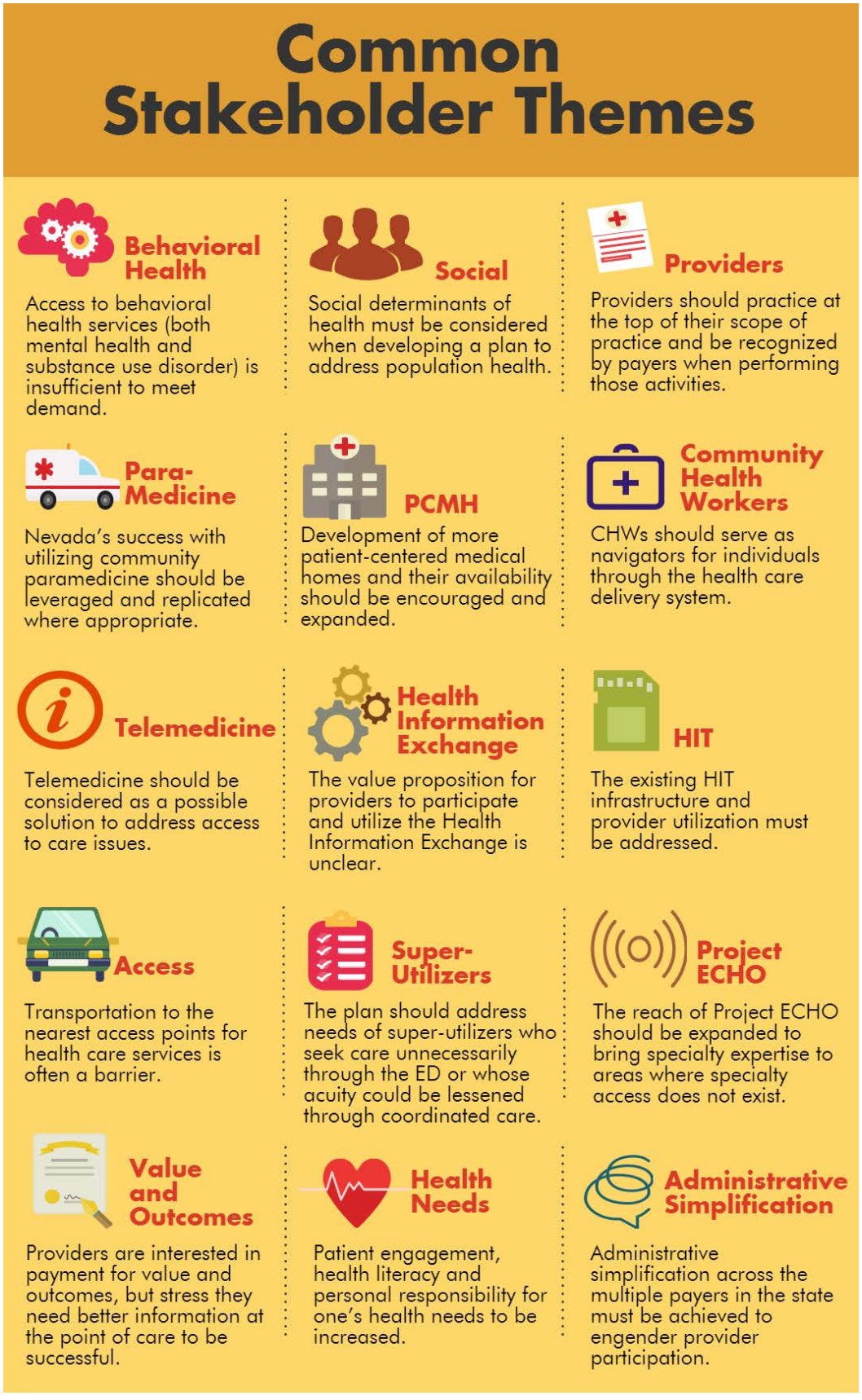
Stakeholder Webinar Updates

The DHCFP published webinars via the DHCFP SIM website for interested parties. These webinars provided updates on the SIM project, relevant activities of workgroups and taskforces, and provided additional transparency into the status of this project. A mechanism for public feedback was made available with each webinar.

Common Stakeholder Themes

Through the extensive stakeholder engagement process, certain common themes emerged, which are detailed in *Figure 6*.

Figure 6: Common Stakeholder Themes



C. Multi-Payer Involvement

Improving Nevada's population health through delivery system and payment transformation requires a concerted effort across multiple payers. Alignment of payers with a singular voice and a united focus is imperative to obtain the degree of provider buy-in to achieve success. From application for the SIM Round Two Model Design funding through stakeholder engagement and development of the SHSIP, Nevada has convened and engaged a core set of payers that are representative of employers and industry in the state. A summary of each of these payers and their Nevada presence is detailed in *Figure 7*.

Figure 7: Key Nevada Payers

Key Nevada Payers	
Payer	**Type**
• DHCFP • Contracted MCOs: o Amerigroup o United HealthCare/Health Plan of Nevada	• Medicaid and CHIP
• PEBP • Contracted Health Plans: o Hometown Health o United HealthCare/Health Plan of Nevada	• Nevada's State Public Employees
UnitedHealthCare/Health Plan of Nevada	• Commercial (also see Medicaid/CHIP and PEBP) • Medicare Advantage Plans
Hometown Health (Renown Health)	• Commercial (also see PEBP) • Medicare Advantage Plans
Anthem, Inc.	• Commercial • Medicare Advantage Plans
Culinary Health Fund	• Culinary Workers' Union
Indian Health Services	• Services for American Indians and/or Alaskan Natives who are enrolled members or descendants of a federally recognized tribe

To achieve consensus and a unified voice across payers, Nevada has established and convened the payers noted in *Figure 7* through the MPC. The MPC brings together payers in the state participating in the SIM effort. This body is charged with reaching consensus on payer approaches and supports regarding various SHSIP and population health initiatives.

The MPC will serve as a committee to the Population Health Improvement Council (PHIC), which is described in detail in *Section VI.A.1*.

D. Leveraging Existing Initiatives

Nevada plans to leverage local, state and federal initiatives to accomplish health care delivery system and payment transformation. Through the stakeholder engagement process, several initiatives, both private and public, were identified as having goals consistent with the priority health issues shown on the driver diagram (*Attachment F*). These initiatives have been identified for potential coordination:

- ***Paramedicine Efforts:*** Two community paramedicine efforts support fragile transitions from an inpatient to an outpatient setting.
- ***Balancing Incentive Program (BIP)*:** The Nevada 2-1-1 system, funded through the BIP program, helps connect individuals with resources and assists in navigating the health care system.
- ***Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD):*** This expired grant program educated, supported and incentivized patients to modify behavior and achieve targeted health improvement goals. Although expired, Nevada will leverage the success and lessons learned from this grant program.
- ***Medicaid Electronic Health Record (EHR) Incentive Program:*** The federally funded Medicaid EHR Incentive Program assists providers with adoption and Meaningful Use (MU) of EHRs.
- ***Million Hearts Campaign:*** Nevada is an active participant in the Million Hearts Campaign, which seeks to prevent heart attacks and strokes.
- ***Certified Community Behavioral Health Clinics (CCBHCs):*** Nevada received a CCBHC grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), which will identify behavioral health clinics, promote integration of behavioral and physical health, as well as introduce value-based reimbursement for these clinics.
- ***Children's Heart Center Healthy Hearts Program:*** This program promotes healthy lifestyles for the entire family with an emphasis on modifying behaviors, improving eating habits, increasing physical activity and improving self-esteem.
- ***The National Governors Association (NGA) Medicaid Transformation Project*:** Implements an innovative, cost-effective approach to address the behavioral health issues in Nevada's youth population, ages 11 to 18 years, and transitions the current crisis-based service system to a system of prevention and early intervention.
- ***Project ECHO:*** Project ECHO increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions by engaging them in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub.[i]
- ***Peer Support Specialists:*** Individuals with appropriate training who also are in recovery or have significant life-altering experiences assist other individuals with

substance use or mental health disorders. Peer support services are available in the community through several private and public organizations.

- Public Health Programs:
  - *Substance Abuse Prevention and Treatment Agency (SAPTA):* With support from SAMHSA, SAPTA seeks to reduce the impact of substance abuse by:
    - Identifying alcohol and drug abuse patterns
    - Supporting a continuum of services, including prevention, early intervention, treatment and recovery support
    - Providing regulatory oversight and funding for community based public and nonprofit organizations
    - Developing and implementing a state plan for prevention and treatment
    - Providing coordination of state and federal funding
    - Developing standards for certification of prevention and treatment programs
  - *Nevada's Women, Infants and Children (WIC) Program:* This program seeks to promote and protect the health of women of childbearing age, infants, children and adolescents, including children and youth with special health care needs. Programs are designed to:
    - Reduce infant mortality
    - Increase the number of children receiving health assessments, including follow-up, diagnoses of condition(s) and treatment services
    - Collect and analyze surveillance data of the MCH population
    - Improve access
    - Implement family-centered and community based systems of care
    - Assist in identifying a medical home
    - Support other programs such as community health centers, WIC, Medicaid and Nevada Check-up
  - *Obesity Prevention and School Health Program:* This program combats obesity through environmental and system changes that focus on school health, worksite wellness, and early care and education strategies.
  - *Community Health Worker Program:* This program develops core skills and competency-based curriculum for CHWs to serve as educators, informal counselors, advocates and liaisons, linking communities to health and social services in a culturally competent way.
  - *Office of Suicide Prevention:* This program serves as a clearinghouse for suicide and suicide prevention information in Nevada and is responsible for

development, implementation and evaluation of the Nevada Suicide Prevention Plan (NSPP). This office also focuses on a related veterans' initiative.

- *Diabetes Prevention and Control Program:* This program provides education, monitors policy and identifies strategic partners to help reduce disease, disability and death related to pre-diabetes and diabetes through education, monitoring policy and identifying partners.
- *Tobacco Prevention and Control Program:* This program seeks to prevent tobacco use initiation, promotes quitting tobacco use, provides a Quitline, promotes elimination of nonsmoker exposure to secondhand smoke, and identifies and eliminates disparities related to tobacco use and its effects among different population groups to reduce disease, disability and death related to tobacco use.

IV. CURRENT NEVADA ENVIRONMENT

The World Health Organization (WHO) defines "health" as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[ii] The United Health Foundation, in partnership with the American Public Health Association, and Partnership for Prevention™, publishes America's Health Rankings annually.[iii] This report is developed from a model that was built on the WHO definition. To calculate the rankings, determinants of health are divided into four categories: behavior, community and environment, policy and clinical care. These determinants account for 75 percent of each state's final ranking. Many of the statistics cited in this plan are from America's Health Rankings. Therefore, Nevada's state demographics related to population, geography, race, education and income are important to understand because they impact the state's overall health status and they influence the road map to improve the state's ranking.

Additionally, an understanding of the state and payer demographics is important to identify trends, disparities or needs and to establish population health improvement priorities.

A. State Demographics

Geographically, Nevada is the seventh largest state in the United States, covering 110,567 square miles.[iv] However, Nevada is only the 35th most populous state. Nevada has fewer people residing in a much larger geographical area than the majority of other states.[v] There are 16 counties and one independent city (Carson City) in the state.

According to the U.S. Census Bureau, Nevada has three urbanized areas: Las Vegas-Henderson, Reno and Carson City.vi These urban areas account for 88 percent of the state's population. The remaining 12 percent of the state's population reside in three rural and 11 frontier areas. The U.S. Census Bureau defines an urbanized area as an area which consists of densely developed territory that contains 50,000 people or more.vii A rural area encompasses all population, housing and territory not included in an urban area.viii Frontier areas are sparsely populated rural areas that are isolated from population centers and services.

According to the U.S. Census Bureau, the population estimate for Nevada in 2014 was 2,839,099, which represents a 5.1 percent increase from 2010. Nevada saw an increase in population growth of 35 percent from 2000 to 2010 and has one of the strongest annual growth rates in the country of 1.08 percent, placing it 16th in the nation. Nevada's growth is expected to continue, reaching a population of 3.36 million residents by 2030.

The largest metropolitan areas include Las Vegas, Henderson and North Las Vegas in Clark County and Reno in Washoe County. Henderson and North Las Vegas are among the 20 fastest growing cities in the United States.[ix]

According to the Affordable Care Act (ACA), a frontier health professional shortage area has a population density of fewer than six persons per square mile within the service area; and the distance or time for the population to access care is excessive. Current criteria for health professional shortage areas' (HPSAs) geographic designation define "excessive" as

more than 30 minutes' travel time away, or otherwise inaccessible.[x] Much of the state has sparse geographically isolated populations, which result in a greater challenge to recruit health care professionals.

There are 11 counties that are designated as frontier HPSAs. The National Rural Health Association (NRHA) provides distinct characteristics of frontier areas that differ from rural areas, including:[xi]

- Do not support health care services and lack the capacity to develop and sustain a comprehensive system of care
- Are more likely to lack health insurance
- Generally have lower incomes
- Have a higher percentage of older adults requiring more health care services per person[xii]

According to the 2014 census, 49.7 percent of the Nevada population is female, 14.2 percent of the population is 65 years of age or older, and the average household size is 2.70 persons per household. *Figure 8* presents the 2014 population by age category.

Figure 8: Nevada Age Demographics

Age Range	Percent of Population
Under Age 18	23.4%
Over 18 and under 65	62.4%
65 years and Over	14.2%

The aforementioned trends indicate that growth is projected to continue. However, nearly 60 percent of the population in rural counties shrank in 2013, which is an increase from 50 percent in 2009 and 40 percent from late 1990.[xiii] Thus, much of the growth occurred in urban areas.

These shifts in the Nevada population have created the current situation where rural and frontier counties struggle to provide for an aging population with limited financial resources, chronic medical diseases and the lack of access health services.[xiv] Efforts to provide health services and improve overall well-being must be prioritized for these individuals in order to fulfill Nevada's goal of improving the health status of all Nevadans.

Race/Ethnicity

The U.S. Census Bureau collects race data from census reports based on self-identification. The 2010 census data show that 76.2 percent of the state's population is White, 9.1 percent is African-American/Black, 8.3 percent is Asian, 1.6 percent is American Indian and Alaska Native, 0.7 percent is Native Hawaiian and other Pacific Islander, and 4 percent of the population chose to provide two or more races in their census reporting. These race categories are mandated by the Office of Management and Budget's (OMB) 1997 standards.

In addition to the self-identified race categories, respondents also can indicate whether they are of Hispanic origin, which is separate from race. Of Nevada's total population, 27.8 percent of Nevadans reported they were of Hispanic origin.[xv,xvi] There are 21 tribes in Nevada. Tribes with federal recognition are eligible for funding and services through IHS within the U.S. DHHS.

Education

Figure 9 summarizes the percentage of the population of persons 25 years of age and older with various education levels from 2009-2013, as reported by the U. S. Department of Agriculture (USDA) Economic Research Service (ERS).[xvii] Of these Nevadans, 15.4 percent have not completed high school, but high school completion rates, as well as completion of some college education, are higher in the rural areas versus the urban areas. College completion rates are 22.4 percent, with the majority of those completing college residing in urban areas.

Figure 9: Nevada Levels of Education

Education Level	Rural	Urban	Total
Not Completing High School	14.2%	15.5%	15.4%
Completing High School Only	31.5%	28.4%	28.7%
Completing Some College	37.4%	33.1%	33.5%
Completing College	16.9%	23.0%	22.4%

Figure 9 provides valuable data when considering education and its role in health status. Individuals who complete college live five years longer than individuals who have not completed high school.[xviii] Studies have shown that better educated persons are less likely to have or succumb to common chronic diseases, such as heart disease or diabetes, and are less likely to be overweight/obese or smoke cigarettes. Having an educated parent also can have lasting effects on the health of future generations. One study showed that the infant mortality rate for women with college degrees was half of that for women who did not complete high school (4.2 percent compared to 8.1 percent, respectively).[xix] Furthermore, only 13.3 percent of children born to parents without a college degree went on to pursue an advanced degree.[xx] According to the Robert Wood Johnson Foundation, educated individuals have higher earnings, increased access to healthy food options, live in safe communities and have a reduced burden of disease.

Income

In 2013, the USDA ERS reported the average per capita income for Nevadans, which includes both family and nonfamily classifications, was $39,235, a 1.4 percent decrease from 2012. As reflected in *Figure 10*, the income per capita and the poverty rate are slightly different between the rural and frontier counties and urban counties. Nevadans' median income was lower than the national average in 2012 and 2013, resulting in a higher poverty rate when compared to the U.S. poverty rate.[xxi]

Figure 10: Nevada Income per Capita[xxii]

Income Per Capita	2012	2014	Percent Change	Poverty Rate (2013)
Nevada				
Urban*	$39,504	$38,932	-1.4%	16.1
Rural*	$45,572	$42,055	-1.2%	13.2
Combined	$39,805	$39,235	-1.4%	15.8
United States				
Urban	$46,331	$46,177	-0.3%	15.4
Rural	$36,269	$36,517	0.7%	18.5
Combined	$44,849	$44,765	-0.2%	15.8

** The terms "rural" and "urban" here refer to data for nonmetro and metro areas, a county-level classification defined by the Office of Management and Budget. The February 2013 version of nonmetro and metro areas was utilized, unless otherwise noted, because it reflects conditions at the beginning of the decade. http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural.aspx provides a discussion of differences between nonmetro and metro categories and the U.S. Census Bureau's rural-urban classification.*

Unemployment

The U.S. Department of Labor, Bureau of Labor Statistics (BLS) reported on its website that the unemployment rate in Nevada has decreased from 7.1 percent in April 2015 to 6.7 percent in September 2015. The BLS utilizes the North American Industry Classification System (NAICS) to report on labor statistics. This standard is used by federal agencies in classifying business establishments for the purpose of collecting, analyzing and publishing data related to the United States' business economy.[xxiii] These classifications are based on the principal product or activity determined by annual sales volume.[xxiv]

Figure 11 provides the number of jobs (in thousands) in September 2015 by NAICS industry category, as reported by the BLS and lists the number of jobs in Nevada from most to least by industry, using the NAICS. The top three industries comprise 59 percent of the state's jobs. Those leading industries are:

- Leisure and Hospitality (28 percent)
- Trade, Transportation and Utilities (18 percent)
- Professional and Business Services (13 percent)

Figure 11: Nevada Industries and Jobs[xxv]

Industry Category	Number of Jobs *(in thousands)*	Percent of Total Jobs
Leisure and Hospitality	358.2	28%
Trade, Transportation and Utilities	231.2	18%
Professional and Business Services	162.6	13%
Government	154.9	12%
Education and Health Services	122.5	10%
Construction	70.2	6%
Financial Activities	56.6	4%
Manufacturing	42.3	4%
Other Services	36.1	3%
Information	13.8	1%
Mining and Logging	13.3	1%
Total	1,261.7	100%

The Nevada Department of Employment, Training and Rehabilitation (DETR) uses the NAICS when reporting short-term (two-year) and long-term (10-year) industry projections. DETR reported in the *2012–2022 Industry Projections Review* that Nevada's total industrial employment is expected to increase by 160,500 jobs in 2022 with 118,000 of those jobs in service-providing industries. The long-term projection indicated the largest anticipated growth in the Leisure and Hospitality category, which is expected to be generated in the accommodation and food services sector.

Identify Growth Trends and Growth Areas

The Nevada State Demographer's Office at the University of Nevada, Reno released population projections through 2033 for Nevada and its individual counties, projecting a statewide increase in population of 528,107 over a 20-year period.[xxvi] The projection was created using the Regional Economics Model, Inc. (REMI) and Moody's Economy (https://www.moodys.com) models. These models consider the historic relationship between the state's economy and demographic composition, and national changes. According to the state demographer, 58.6 percent of the job losses attributed to the housing bubble, the spike in fuel prices and the financial crisis had been regained by 2010.[xxvii] Gaming will continue to be the biggest driver for employment.

Despite the economic and employment gains recovered, Nevada's unemployment rate is slightly higher than the U.S. average of 5 percent in November 2015.[xxviii] Economic policy and statewide efforts should continue to promote an inclusive economy that diversifies, grows and provides employment opportunities for those living in urban, rural and frontier areas. According to the Robert Wood Johnson Foundation, stable and well-paying jobs contribute to better health and longer lifespans. Staying active, and having a healthy work routine, improves physical and mental well-being through affordability of health insurance, social interactions and a sense of purpose.[xxix]

B. Payer Environment

Outside of increasing the number and availability of health care providers, improved access to quality integrated health care depends, in part, upon the actions of payers and upon the extent of health insurance coverage. The SHSIP calls for public and commercial payer collaboration to continue to influence the health care delivery system by moving to value-based payments that promote quality care and improve health outcomes.

The current Nevada payer environment includes public payers, such as Medicaid, CHIP and PEBP, as well as a diverse group of private payers. The Nevada Division of Insurance, Life and Health Section reports 20 licensed payers, with most payers offering products to small and larger employers, as well as to individuals.

Eligible individuals may purchase private plans through the Silver State Health Insurance Exchange (SSHIX). Nevada named the online Marketplace Nevada Health Link. Currently, the three state-certified medical plans participating in Nevada Health Link include Anthem BlueCross BlueShield, United HealthCare/Health Plan of Nevada and Prominence Health Plan. During the 2015 open enrollment period, 73,596 individuals had plan selections made on the Health Insurance Exchange.

As of June 2015, 60,879 Nevadans were enrolled in Marketplace plans, with 81.7 percent receiving advanced premium tax credits.[xxx] In addition, 28,290 individuals were assessed as eligible for Medicaid/CHIP by the Marketplace and referred to the appropriate Nevada agency for final verification.

Nevada opted to expand Medicaid in January 2014. Expansion of the Medicaid-eligible population made a substantial contribution to the lower rate of uninsured Nevadans.[xxxi] Newly covered Medicaid enrollees totaled 197,916 people in October 2015, of which 33,281 were covered under FFS and 164,635 were covered by MCOs.[xxxii]

Following the introduction of Nevada's private health insurance marketplace and the expansion of Medicaid coverage, Nevada's uninsured rate dropped from 20.7 percent in 2013 to 15.2 percent in 2014. *Figure 12* provides a breakdown of the health insurance coverage status of Nevadans by age group. Between 2013 and 2014, private health insurance coverage increased for Nevadans ages 18 to 65 years, and Nevadans under 65 years of age continue to obtain their primary health insurance coverage through private payers. In addition, public health insurance coverage increased among all Nevadans that are under 65 years of age.

Figure 12: Insurance Status of Nevadans in 2013 and 2014 by Age Group

Percentage Coverage	2013 American Community Survey (ACS)	2014 ACS
Under 18 years		
No health insurance	14.9	9.6
With private only	56.6	56.5
With public only	25.5	30.1
With both private and public	2.9	3.8
18 to 34 years		
No health insurance	32.7	24.5
With private only	59.0	61.8
With public only	6.7	11.6
With both private and public	1.6	2.1
35 to 64 years		
No health insurance	23.6	17.9
With private only	64.3	66.7
With public only	8.5	11.1
With both private and public	3.6	4.3
65 years and over		
No health insurance	2.1	1.8
With private only	3.7	2.8
With public only	44.0	45.5
With both private and public	50.2	49.8

American Community Survey (ACS) Nevada State Profile (revised April 2015)

The ability of payers and providers to improve the health of all Nevadans depends upon the level of access Nevadans have to health services. Understanding the characteristics of Nevada's uninsured population will improve the targeting of health insurance enrollment efforts to increase access. Increased health insurance coverage will allow Nevada to mitigate the access barrier of being uninsured. In addition, public health interventions will continue to reach uninsured Nevadans, as well as insured Nevadans, to address access gaps.

Figure 13 provides a breakdown of Nevada's uninsured population prior to and following Medicaid expansion. The uninsured rate decreased across all demographic groups. Nonetheless, substantial proportions of people remain uninsured, and disparities among demographic groups persist in the uninsured rate. Notably, the uninsured rate remains higher than average among American Indians and Hispanics. The uninsured rate also remains much higher for noncitizens, but the Census Bureau data do not clarify the uninsured rate according to immigration status. In addition, the uninsured rate remains higher among people with lower levels of educational attainment. Surprisingly, Nevadans not in the labor force have a lower uninsured rate compared to people in the labor force, which may be attributed to the inclusion of retired workers in the category of people not in the labor force. Other people categorized as not in the labor force include students,

homemakers and seasonal workers not looking for work. This type of analysis may help tailor population health improvement programs to better meet the needs of specific subgroups and may allow for improved targeting of health insurance enrollment efforts.

Figure 13: Demographic Characteristics of Uninsured Nevadans in 2014

Demographic Characteristic (civilian noninstitutionalized population)		Percentage Uninsured	
		2013 ACS	2014 ACS
Total		20.7	15.2
Age			
	Under 18 years	14.9	9.6
	18 to 64 years	27.0	20.4
	65 years and older	2.1	1.8
Race			
	White	18.5	13.5
	Black or African-American	22.3	14.4
	American Indian and Alaska Native	29.4	19.7
	Asian	18.2	12.9
	Native Hawaiian and other Pacific Islander	31.3	19.7
	Some other race	36.4	31.3
	Two or more races	17.3	11.6
Hispanic Or Latino Origin			
	Hispanic or Latino (of any race)	32.5	25.2
	Not Hispanic or Latino	16.2	11.3
Nativity And Citizenship Status			
	Native-born citizen	16.8	11.6
	Naturalized citizen	18.3	9.9
	Not a citizen	54.2	46.8
Educational Attainment (Age 25+)			
	Less than high school graduate	38.0	31.7
	High school graduate, GED or alternative	25.4	19.3
	Some college or associate's degree	17.7	13.3
	Bachelor's degree or higher	10.6	7.6
Employment Status (Age 18+)			
	In labor force	24.3	18.8
	Employed	*20.8*	*17.3*
	Unemployed	*60.0*	*35.3*
	Not in labor force (e.g., retired workers, students, homemakers, seasonal workers, etc.)	18.8	

American Community Survey (ACS) Nevada State Profile (revised April 2015).

C. Provider Environment

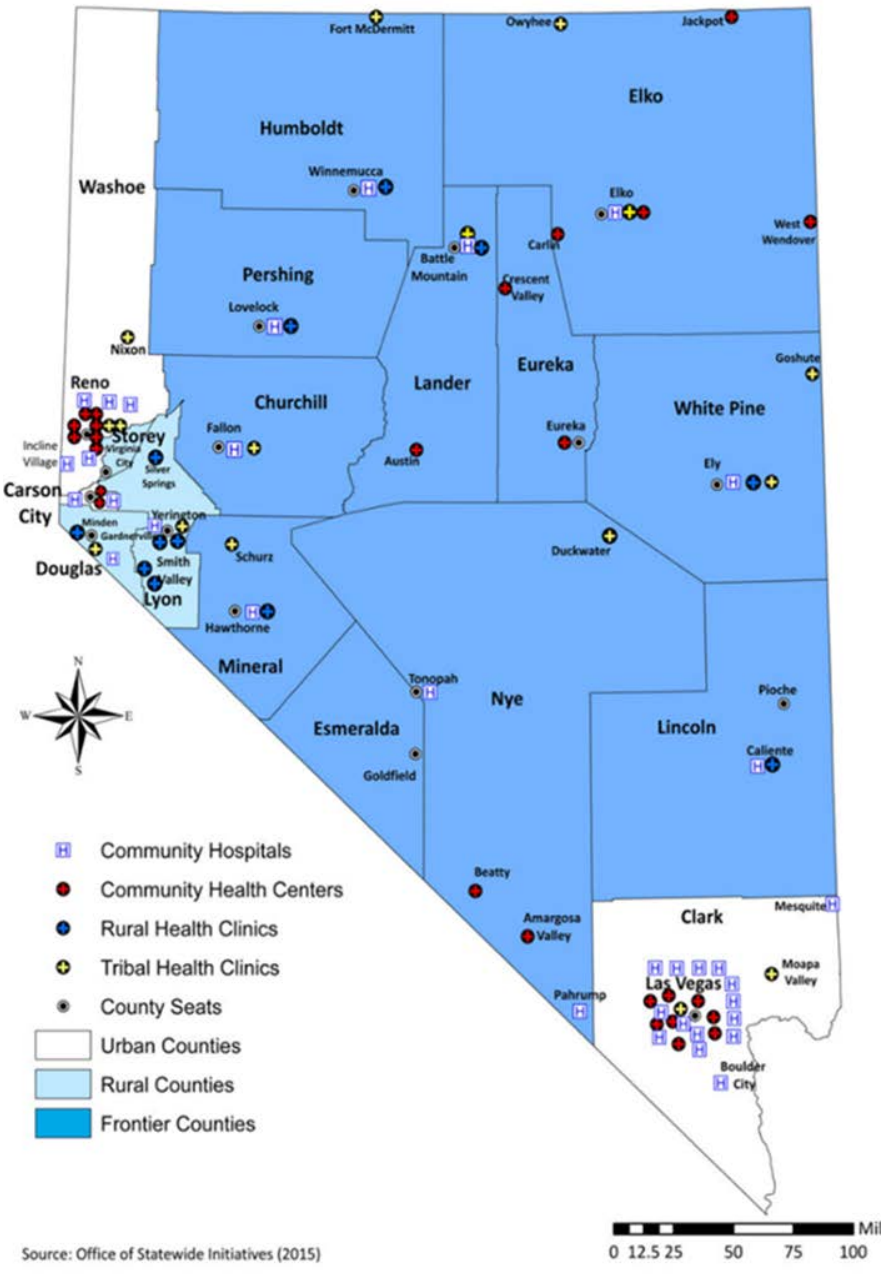
Provider Demographics

The Congressional Research Service (CRS) indicated in a January 2013 report, *Physician Supply and the Affordable Care Act*, that it is important to consider the number of physicians, types of physicians and location of physicians when determining whether there is an adequate supply of physicians. The examination of the state of these conditions for all provider types is key when addressing health care access issues.

As illustrated in *Figure 14*, the locations of health care resources are of particular significance in Nevada, given the frontier nature of the state. The map provides a current snapshot of the major health care facilities. Clark County, the largest urban area in Nevada, is the 15th most populous county in the nation and accounts for 72 percent of the state's population, with just over 2 million citizens. Washoe County is the next most populous county in Nevada, with approximately 434,000 residents. The remaining 400,000 residents live in rural and frontier counties that lack adequate access to health care.

Figure 14: Health Care Resources in Nevada

Health Care Resources in Nevada – 2015*



**Note: Nye County no longer has a medical center.*

The northern and southern urban areas in Nevada are approximately 450 miles apart, which equates to an almost seven-hour trip by automobile. Provider shortages and extreme travel distances to obtain health services complicate the development of an ideal health care delivery system.

Workforce Overview

The statistics identified for inclusion in this document are typically reported using averages or numbers per 100,000 citizens. However, because of the geographic distribution of the state's population and the locations of limited associated health care resources, statistics presented in that manner can be skewed when statistics for rural and frontier counties are combined with urban areas. It is important to keep this in mind when processing the statistical data.

All 16 counties plus Carson City have substantial numbers of HPSAs, characterized by a lack of PCPs, dentists or dental assistants, and psychiatrists. This is not a phenomenon unique to Nevada, as nationwide HPSAs are widespread. *Figure 15* identifies the percentage of the population living in HPSAs by type of region and the number of HPSAs in those regions.

Figure 15: Health Professional Shortage Areas in Nevada

Type of Region	Primary Medical	Dental	Behavioral Health
Rural and Frontier			
% of Population in HPSAs	50.6%	51.4%	100%
Number of HPSAs	40	35	39
Urban			
% of Population in HPSAs	31.8%	29.5%	48.1%
Number of HPSAs	31	21	22
Statewide Total			
% of Population in HPSAs	33.7%	31.7%	38.1%
Number of HPSAs	71	56	61

Note: For primary medical care, the population-to-provider ratio must be at least 3,500-to-1 (3,000-to-1 if unusually high needs). For dental care, the population-to-provider ratio must be at least 5,000-to-1 (4,000-to-1 if there are unusually high needs). For mental health care, the population-to-provider ratio must be at least 30,000-to-1 (20,000-to-1 if there are unusually high needs).

Physicians and Physician Extenders

The Association of American Medical Colleges (AAMC) annually publishes a Physician Workforce Profile by state. For 2014, Nevada ranked 49th in the nation in the number of total active patient care physicians per 100,000 population, with a state median of 225.6 per 100,000, and 48th in the number of active primary care physicians (PCPs) per 100,000 population, with a state median of 83 per 100,000.[xxxiii]

Figure 16 summarizes the number of providers, including physician extenders, by provider type in rural and frontier counties and urban counties, and the statewide numbers per 100,000. When reviewing the numbers of provider types in the rural and frontier areas, it is important to remember that approximately 400,000 residents reside across 86.8 percent of the state's land area. As an example, the presence of two psychiatrists in the rural and frontier counties does not mean that all rural and frontier areas can access those resources due to the vastness of the state.

Figure 16: Number of Health Care Providers in Nevada, According to County Geographic Classification

Numbers of Health Care Providers in Nevada						
	Rural and Frontier Counties		Urban Counties		Statewide	
Provider Type	Number	#/100,000	Number	#/100,000	Number	#/100,000
Physician, PCP	141	49.6	2,301	90.4	2,442	86.3
Physician Assistants	40	14.1	531	20.9	571	20.2
Advanced Practice Registered Nurse (APRN)*	64	22.4	931	36.2	995	34.9
Nurses, non-APRN*	1,696	592.5	23,831	891.8	25,527	1078.5
RN*	1,484	518.4	20,954	815.7	22,438	785.9
LPN*	212	74.1	2,877	112.0	3,089	108.2
Dentists	108	38.0	1,445	56.8	1,553	54.9
Dental Hygienists	104	36.6	943	37.1	1,047	37.0
Behavioral Health	226	121.4	2223	151	2449	148.1
Psychiatrists	2	0.7	178	7.0	180	6.4
Psychologists	17	6.0	356	14.0	373	13.2
Licensed MFTs†	49	17.3	620	25.1	669	24.3
LCSWs	0	14.8	0	22.0	0	21.3
LSWs	0	27.1	0	40.9	0	39.5
Licensed ADGCs†	158	55.5	1,069	42.0	1,227	43.4
EMS Personnel‡	1,715	605.3	4,710	190.9	6,425	233.6
First Responders	439	155.0	162	6.6	601	21.9
Basic	643	227.0	1,222	49.5	1,865	67.8
Intermediate	474	167.3	1,957	79.3	2,431	88.4
Advanced (paramedics)	159	56.1	1,369	55.5	1,528	55.6

*Source: UNSOM, Nevada State Office of Rural Health. "Nevada Rural and Frontier Data Book – Seventh Edition," 2015. *Nursing data from the Nevada State Board of Nursing. "Annual Report: 2014-2015." † MFTs, Marriage and Family Therapists; ADGCS, Alcohol, Drug and Gambling Counselors. ‡ EMS providers must complete certification process by 2015, to retain equivalent levels of new EMS categorization.*

Physician age is a significant factor impacting the provider environment in Nevada in the long term. The AAMC reported that for 2014, 13.5 percent are under age 40; 59.6 percent, more than half of the physician workforce, are approaching retirement, at ages between 40 and 60; and over a quarter, 26.9 percent, of the active physicians are retirement age 60 or older.[xxxiv,xxxv]

Facilities Overview

A diverse range of acute care hospital services, outpatient clinics and medical services are scattered across the state's rural and frontier counties. Of the 34 acute care hospitals in Nevada in 2014, 13 are located in Clark County, six are located in Washoe County/Carson City and 15 are located in rural and frontier counties.[xxxvi] Nationally, Nevada is the state with the highest proportion of for-profit hospitals at 52.6 percent, exceeding the national rate of 21.3 percent. [xxxvii]

In addition, all 15 of the rehabilitation, long-term care and specialty hospitals in Nevada are located in urban counties.[xxxviii]

Figure 17 illustrates the disparity between rural and urban areas in terms of the number of available beds and the number of admissions per 1,000 residents. Rural counties have fewer beds per capita and lower admission rates.

The lower occupancy percentages found in rural hospitals highlight the heightened financial pressures these institutions often face. In August 2015, the Nye Regional Medical Center in Tonopah closed, further reducing access as it was the only hospital located within a 100 mile radius. Reportedly, as of November 2015, Renown Health and the Nye County Board of Commissioners approved a Letter of Intent between Nye Regional Medical Center and Renown Health to reopen the facility with discussions ongoing regarding the specific medical services to be made available.[xxxix]

Figure 17: Usage of Nevada Acute Care Hospitals by Region for 2005 and 2014

Utilization Measure	2005	2014
Licensed Beds per 1,000		
Nevada	1.9	2.0
Clark County	1.9	1.8
Washoe County/Carson City	2.6	3.2
Rural Counties	1.0	1.2
Admissions per 1,000		
Nevada	97.7	88.5
Clark County	101.7	87.2
Washoe County/Carson City	117.1	121.5
Rural Counties	37.5	39.2
Occupancy Percentage		
Nevada	67.9%	60.1%
Clark County	72.9%	68.1%
Washoe County/Carson City	56.6%	47.4%
Rural Counties	30.2%	29.1%

State of Nevada, Dept. of Health and Human Services, Div. of Health Care Financing and Policy. "Report on Activities and Operations," October 2015.

Federally Qualified Health Centers and Rural Health Clinics

Four Federally Qualified Health Centers (FQHCs) offer care at more than 26 locations across the state.[xl,xli] In addition, 12 Rural Health Clinics (RHCs) operate in Nevada.[xlii] These

16 providers have already achieved recognition by the National Committee for Quality Assurance (NCQA) as PCMHs. According to Nancy Hook, Executive Director of the Nevada Primary Care Association (PCA), members of the Community Health Centers (CHCs) were aware of a national drive to certify CHCs, and although Nevada did not receive federal funds to support this initiative, they saw the importance of becoming certified. According to the PCA, these sites are integrating behavioral health and primary care.

Indian Health Services

IHS is the principal federal health care provider and health advocate for American Indians and Alaska Natives (AIs/ANs) who have treaty rights to federal health care services through IHS.[xliii] The agency operates 13 Tribal Health Clinics and Centers across Nevada. These facilities provide services to an estimated tribal population of 22,900.[xliv] Nonetheless, many tribal members living off the reservation may not be eligible to receive IHS care and IHS-contracted services due to limited funding.[xlv] Furthermore, federal funding is limited to federally recognized tribes. As discussed in this section, there are many non-federally recognized tribes in Nevada.

The Inter-Tribal Council of Nevada also recognizes tribes and provides services to 27 tribes and community organizations that serve Nevada and the Great Basin Region.[xlvi] The Inter-Tribal Council of Nevada, Inc. serves as a large political body for the small Nevada tribes and promotes a variety of programs whose goals are to improve the well-being of community members by sponsoring health, educational, social, economic and job opportunity programs. Tribes and community organizations served by the Inter-Tribal Council of Nevada do not have to be federally recognized to receive funding.

In October 2015, CMS requested comments on a policy change regarding the circumstances in which 100 percent federal funding would be available for services furnished to Medicaid-eligible AI/AN individuals through IHS facilities. The intent of the policy change would be to improve access to care for AI/AN Medicaid beneficiaries and expand the circumstances in which state Medicaid payments for services furnished to AI/AN beneficiaries would be considered to be "received through" an IHS/Tribal facility, and therefore qualify for 100 percent Federal Medical Assistance Percentage (FMAP). If the services are not considered to be "received through" an IHS/tribal facility, the FMAP varies and states would be responsible for covering the state's share of the FMAP.[xlvii]

Veterans Administration

Within Nevada, the Veterans Administration (VA) operates two medical centers, four outpatient clinics, six community based outpatient clinics, three Vet Centers, and one outreach clinic.[xlviii] The medical centers include Ioannis A. Lougaris Veterans Administration Medical Center, which is part of the Sierra Nevada Health Care System located in Reno and the Southern Nevada Healthcare System in Las Vegas.

Nevada veterans reside in one of three Veterans Integrated Service Networks (VISNs) that cross state lines. The Southern Nevada Healthcare System services are available to more than 240,000 veterans in their catchment area, which includes residents of Clark, Esmeralda, Lincoln and Nye counties grouped together with portions of Southern

California.[xlix] Residents of Elko, Eureka and White Pine counties are grouped together with portions of several mountain states in a VISN for which no VA medical centers are located in Nevada.[l] Residents of the remaining counties are grouped together with portions of Northern California and are served by the Reno campus of the Ioannis A. Lougaris Veterans Administration Medical Center.[li] Approximately 120,000 veterans reside in this region, with Reno representing the largest urban area. When specialty care is not available, support is provided through a variety of means, including referrals to community hospitals and VA medical centers.

The Mike O'Callaghan Federal Medical Center is a federal hospital in Las Vegas that is operated by the U.S. Air Force and VA patients also have privileges at the hospital.[lii]

The VISN networks cover vast distances, which negatively impact Nevada veterans' ability to access care.

Community Health Workers

CHWs have been utilized in Nevada since 2013, when a pilot training program was launched and efforts were made to standardize the CHW curriculum and certification system with Truckee Meadows Community College (TMCC) and the College of Southern Nevada (CSN). The pilot CHW program, coordinated through the Governor's Office of Economic Development (GOED) and funded through the Nevada DETR, was a free eight-week program that yielded 37 CHW certificate graduates in fall 2014. To date, the schools have had approximately 70 certificate graduates.

The BLS calculates the number of CHWs in Nevada at 160 as of May 2014, all of which are located in the Las Vegas area.

Community Paramedicine

The success of the Regional Emergency Medical Services Authority's (REMSA) and Humboldt General's Community paramedicine programs, as well as the success of similar programs in other states, have proven that the role of Emergency Response teams can be expanded to better serve the health care delivery system. It is important to note that the career of Emergency Medical Technicians (EMTs) and paramedicine professionals is on the rise. In fact, according to the BLS, employment of EMTs and paramedics is expected to rise 23 percent between 2012 and 2022. The Nevada Rural and Frontier Data Book states that in 2012, there were 6,425 licensed EMTs in Nevada.

There are four accredited paramedicine programs in Nevada, two in Las Vegas and two in Reno. Programs are accredited through the Committee on Accreditation of EMS Education Programs (CoAEMSP), which operates under the Commission on Accreditation of Allied Health Education Programs (CAAHEP). In addition, other EMT programs offer certificates upon completion.

The REMSA program has graduation rates of approximately 25 paramedics every 14 months. They graduated 27 students in February 2015, anticipate 10 more in February 2016 and have a class of 25 students ready for the next session's start in January 2016.

The National College of Technical Instruction (NCTI) offers classes for all levels of Emergency Management. The college typically graduates more than 175 students per year across all levels of the program.

Under Senate Bill (SB) 100, passed in 2013, four former levels of EMS certification are no longer valid starting in 2016. Previously certified "EMS-paramedics" who do not complete the new certification process are to be automatically downgraded to "advanced-EMT." These practitioners should be encouraged to complete paramedic certification to avoid a negative impact on the community paramedicine programs.

Behavioral Health

The eight psychiatric hospitals in Nevada all operate within urban counties.[liii] SAMHSA found that from 2009 to 2013, 69 percent of adults, aged 18 or older with any mental illness and 70.1 percent of adolescents, aged 12-17 with major depressive episodes did not receive treatment.[liv] During a meeting in Hawthorne, Nevada, stakeholders explained that it was not unusual for patients in a behavioral health crisis to present at the ED and remain there for several days while the rural hospital waited for a mental health facility bed to become available either in Nevada or a bordering state. Very often, air transport was the only means to transfer the patient, given the remote location of the rural hospital. At the Ely, Nevada, community stakeholder meeting, participants indicated that once a patient's behavioral health crisis situation had been stabilized, the patient could wait weeks and sometimes months before they could schedule a follow-up appointment.

Stakeholders in all Nevada community meetings expressed that there is a severe shortage of behavioral health providers in the state.

Skilled Nursing Facilities

The type of ownership for skilled nursing facilities (SNFs) in Nevada – 73.6 percent for-profit, 13.2 percent nonprofit and 11.3 percent government-owned – approximates the national average (68.9 percent for-profit, 24.1 percent nonprofit and 6.2 percent government-owned).[lv] SNFs are routinely reviewed for compliance with regulations. According to the Kaiser Commission on Medicaid and the Uninsured, SNFs averaged 13.9 deficiencies per facility statewide compared to the national average of 8.0 deficiencies.[lvi]

Transportation

During the stakeholder engagement process, the lack of adequate transportation came up time and time again. Rural communities especially need readily available scheduled transportation to move patients the long distances to get to specialists or obtain treatments not available in the rural and frontier areas.

Health Systems and Innovative Initiatives

Although the discussions in this section highlight the challenges in the current provider environment, it should be noted that Nevada's health care community has received accolades from CMS and other national organizations for their involvement in transformation efforts that have been initiated across the state. Many providers are already participating in CMS alternative payment models, such as the Medicare Shared Savings

Program and Bundled Payments for Care Improvements, and have begun their own transition toward integrated care models.

Healthy People 2020 highlights the importance of addressing the social determinants of health. In recognition of this need, innovative providers in Nevada are developing partnerships with community coalitions and nontraditional health care organizations (e.g., faith-based organizations, food banks, etc.) to address the conditions of daily life and their impact on an individual's health. These initiatives are being pursued even though these efforts are not fully supported by current reimbursement models.

Operational plans for SHSIP implementation include creating a platform for these innovative providers to collaborate with the major health plans and payers to streamline and maximize the benefits of these innovations to improve population health in Nevada.

Patient-Centered Medical Homes

In 2015, the Nevada legislative session addressed the definition of a PCMH and elements of a PCMH model in the state. Currently, NCQA has recognized PCMH providers in these urban and rural communities:[lvii]

- Boulder City
- Carlin
- Carson City
- Elko
- Eureka
- Fallon
- Henderson
- Jackpot
- Las Vegas
- Pahrump
- Reno
- Sparks
- West Wendover

There are two FQHCs and 12 RHCS that have achieved PCMH recognition from NCQA.[lviii] Through stakeholder engagement, Chris Bosse, Vice President of Government Relations for Renown Health (Renown), indicated that Renown has five practice locations that are recognized as PCMHs. At this time, Renown does not plan to pursue PCMH recognition for its other primary care and specialty locations. Instead, Renown is focusing on care gap management and streamlining operations to enhance the provider and patient experience. United HealthCare/Health Plan of Nevada has invested in the PCMH model for Southwest Medical Associates, its large primary care and multispecialty physician group practice located in urban and rural markets.

D. Legislative Actions

The Nevada Legislature has enacted a number of laws designed to improve Nevadans' access to health care, including:

- ***Patient-Centered Medical Homes:*** The state recently made strides in expanding the number of PCMHs through the passage of SB6, amending Nevada Revised Statutes (NRS) Chapter 439. The PCMH model was defined, which emphasizes

enhanced access to preventive care, allows incentives between insurers and PCMHs, and requires public links for improved patient education regarding the PCMH model.

- ***Community Health Workers****:* The role of CHWs will be an important part of Nevada's workforce development plan. The recent passage of SB498, amending NRS Chapter 499, standardized and defined a CHW Pool and requires that pool to obtain a license from the DHHS.
- ***Community Paramedicine****:* During the 2015 Nevada legislative session, community paramedicine was defined through the passage of Assembly Bill (AB) 305, amending Chapter 450B of the NRS, to include "services provided by an EMT, advanced emergency medical technician or paramedic to certain patients who do not require emergency medical transportation." These services must be provided in a "manner that is integrated with the local and regional health care and social service resources available in the community." This law also defines the permits required to operate as a community paramedicine entity.
- ***Telemedicine:*** In 2011, the Nevada Legislature defined telemedicine and established its practice. The promotion of telehealth continued with the passage of AB292 during the 2015 legislative session. AB292 defined telehealth as, "A mode of delivering health services using information and audiovisual communication technology, not including standard telephone, facsimile or electronic mail, to enable diagnosis, consultation, treatment, care management and provision of information to patients from providers of health care at other locations." As a result of AB292, Chapter 629 of NRS requires prior authorization and payment of service to be covered to the same extent as though services are provided in person or by other means. AB292 further defines the definition of telehealth and requires private insurance and Medicaid to pay for telehealth services. The law further states that providers that are not within the same network can be used to provide telehealth services.
- ***Interstate Medical Licensing Compact:*** Through updates to Title 54 of NRS as amended by SB251, Nevada approved the Interstate Medical Licensing Compact, allowing for reciprocity of providers from other states using an expedited license process for eligible physicians. The law states that if a physician is licensed in Nevada, the Compact provides for reciprocal licensure for that physician or in all other member states of the Compact. The Compact regulates the licensure and discipline of physicians holding reciprocal licenses through the Compact. The Compact represents a national solution to expedite the licensing process for eligible physicians and improves license portability and increases patients' access to care through the reciprocity process. To date, 11 states have passed legislation to become members of the Compact.

V. HEALTH INFORMATION TECHNOLOGY PLAN

A critical element for the success of a transformed delivery system is the support of these efforts through HIT. This section of the SHSIP discusses HIT from the perspective of the current environment, the SIM stakeholder engagement process and input received, needs identified and barriers, strategies, governance and associated timelines.

A. Current Environment

Electronic Health Records

As of September 2015, CMS reports 4,647 EHR incentive payments in Nevada to providers totaling $158,544,665. Of these total dollars, 73 percent were distributed through the Medicaid EHR incentive payment program and the remaining 27 percent through the Medicare EHR incentive payment program.[lix] According to DHHS reports, the Nevada Medicaid incentive payment data through August 24, 2015, reports a total of 501 unique providers paid with 94 percent of those providers being eligible professionals (i.e., physicians, nurse practitioners, certified nurse midwives, dentists and physician assistants [PAs], providing services in a FQHC or RHC). The remaining 6 percent of the providers are eligible hospitals (i.e., acute hospitals, critical access hospitals [CAHs], cancer hospitals and children's hospitals).

During the stakeholder engagement process, some providers stated that they are not adopting or fully using EHRs. The reasons for this lack of participation were varied. Some providers stated they were too close to retirement to invest in EHRs. Others pointed to the investment cost and the insufficiency of the EHR incentive payment to motivate them to purchase a system. Some that had purchased and attempted to implement an EHR system cited expensive interfaces that were required to fully implement and integrate the system with their practice management software or to fully participate with the HIE. Some of these interfaces were quoted at as much as $50,000 per interface.

Health Information Exchange

HealtHIE Nevada, operated by HealthInsight, serves as the state's HIE. It established its first connection in 2011 and began exchanging protected health information (PHI) in early 2012. Today, all FQHCs, all major urban acute care hospitals and approximately one-half of the CAHs and rural hospitals are connected to HealtHIE Nevada. The HIE also includes all major diagnostic laboratories and testing facilities. However, only an estimated 18 percent of physician offices are connected to the HIE and only two EMS agencies are connected.

In terms of the number of individuals' records within HealtHIE Nevada, there are 2,310,346 unique patients represented in the HIE as of November 1, 2015. However, this number consists of Nevadans as well as citizens from other states who received care by a provider contributing to the Nevada HIE. Similarly, Nevadans who received care outside of the state are unlikely to have their records represented in HealtHIE Nevada. The current HIE infrastructure provides for the direct exchange of PHI from provider to provider. However, the query-based exchange function that a provider would use when trying to pull all PHI available on a patient requires patient consent. The current model is an opt-in model for exchanging PHI. Consent options available under the Nevada HIE consist of three options:

1. Patient agrees for all providers to have access to all of the patient's PHI via the HIE
2. Access to PHI is permitted but only in emergency situations
3. Patient refuses to permit sharing of any PHI

Patients refusing to share their PHI still have their PHI loaded into the HIE if the provider participates; however, sharing of that information is not permitted.

Of the more than 2.3 million unique individuals whose PHI is represented in the HIE, approximately 500,000 have consent records. Of these 500,000 consent records, 93 percent are unrestricted sharing, 3 percent are emergency sharing only, and 4 percent do not permit any sharing. Medicaid and CHIP patient consent is automatic. With these variables considered, a relatively small percentage of Nevadans have some portion of their PHI information available in the HIE and an even smaller percentage of Nevadans have complete records in HealtHIE Nevada.

Recently, the consent process has been revised to provide more information to patients and guidance, which promises increased rates of consent for PHI sharing via the HIE. However, if a patient opts out from sharing certain types of PHI in their record (i.e., sensitive PHI: genetic testing, behavioral health services, AIDS/HIV or STDs), the patient is fully opted out. There is currently no capability to suppress only the sensitive PHI from the record.

Regional Extension Center

HealthInsight serves as the Nevada Regional Extension Center (REC), through the programs' federal sunset in February 2016, and assists practices with a number of activities related to the adoption, implementation and MU of EHRs. These services include, but are not limited to:

- Initial readiness assessments
- Work flow analysis
- Selection tools
- Referrals to mentor clinics
- Contract negotiation tools
- Project management and implementation
- Privacy and security best practices
- HIE assistance
- Consultation on getting to MU

The availability of these types of services has been important in attaining the state's progress toward EHR adoption, implementation and MU. However, funding for the REC program expires at the federal level in February 2016. Stakeholders have expressed that

continuation of certain aspects of the REC functions are seen as necessary after the expiration of the REC program funding.

Center for Health Information Analysis for Nevada

CHIA is a research center at the UNLV within the School of Community Health Sciences, which could be queried for reporting and baseline data purposes to support the SHSIP efforts. CHIA is contracted by the Nevada DHHS DHCFP to collect certain billing record fields from all hospital inpatient, outpatient and ambulatory surgical centers. The research center serves the community by making specific Nevada Healthcare-related data and reports available to both the private and public sectors. CHIA does not collect or release direct patient identifiers. CHIA's goal is to provide meaningful data to help organizations researching utilization patterns, health status and related issues.[lx]

Broadband Access

The HIT solutions planned through the SHSIP require the ability of providers and citizens to have reliable and consistent Internet access. Nevada has taken active steps to expand broadband access for its citizens and businesses.

The Nevada Broadband Task Force was established July 15, 2009, by Executive Order of the Governor. This body consists of 12 members and includes representation of rural hospitals, rural K-12 school districts, rural libraries, distance education/higher education, public safety/Nevada Department of Transportation, the telecommunications industry, the cable industry, the wireless industry, local government, Nevada Commission on Economic Development, city/county organizations and Nevada Native Americans. Consistent with the Executive Order, the Nevada Broadband Task Force works to identify and remove barriers to broadband access and identify opportunities for increased broadband applications and adoption in unserved and underserved areas of Nevada. The Task Force also oversees all necessary duties and responsibilities to reach the goal of expanding broadband technology, including the application of federal funding/grants, grant compliance, mapping and data management.[lxi] As part of his 2011 State of the State address, Governor Sandoval stated, "These improved broadband connections will also allow the electronic exchange of health information between providers and hospitals to improve the quality of care."

A 2014 report by Connect Nevada, Nevada's state designee for the U.S. Department of Commerce's State Broadband Initiative grant, found that an estimated 99.73 percent of Nevada households have broadband access via fixed or mobile broadband systems. Rural communities also saw benefits of the broadband initiative, with 95.17 percent of households reporting a fixed broadband service, and 99.57 percent of households reporting fixed or mobile broadband access. The report indicated that, at minimum, households had download speeds of 768 Kbps or higher, and upload speeds of 200 Kbps.[lxii] Additionally, the results of Connect Nevada's 2014 Business Technology Survey revealed that more than four out of five businesses in the state (81 percent) use broadband while 11,000 businesses do not.

B. HIT Stakeholder Engagement

Upon project kickoff, the DHCFP formed a HIT and Data Taskforce to assess the HIT requirements of the state, identify challenges and to develop solutions to enable payment and delivery system reform while leveraging existing infrastructure and efforts. This group began meeting in early April 2015, and they met and contributed on a regular basis throughout the project. A full description of the stakeholder process, representation in the HIT and Data Taskforce, and their charge is represented in the Stakeholder Engagement section of the SHSIP (*Section III.B*).

As part of their work, the HIT and Data Taskforce developed a data asset survey and distributed it to payers and other entities in the state with health information records or other records that would be relevant to efforts to improve population health. This survey was intended to create an inventory of what data exists, in which format and how accessible that data may be. The results of this survey and follow-up discussions informed the development of this plan. The taskforce identified a number of data sources that are necessary and others that would be desirable to support the health care transformation effort. However, the data resides in different databases, in various formats, with different levels of confidence in certain data elements, and different individual identifiers that could not be easily shared due to data format, technology and privacy challenges.

C. HIT Needs and Future Components

The HIT and Data Taskforce identified five primary business needs that they sought to address in the HIT Plan. These business needs included:

- Developing the infrastructure to provide access to demographic and health-related data in disparate location, in various formats, and bring that data together
- Utilizing the disparate data to present information in a useful way to providers, payers and patients for purposes of improving health
- Creating a population health analytics tool to measure population health and population health improvement
- Promoting the increased availability and exchange of PHI through a statewide HIE
- Providing technical and business support to providers adopting, implementing and using HIT in a meaningful way

SIM HIT Domains

Responding to business needs, the taskforce described the ideal interaction between the health care system and HIT to support a transformed health care system in the administrative, provider and patient domains.

Administrative Domain

From an administrative standpoint, Nevada will develop the HIT infrastructure to measure population health and population health improvements at a state level across all payers. The current Nevada environment does not include an APCDR or a robust and widely adopted HIE. However, Nevada does have the benefit of having hospital and hospital facility

claims from all state payers submitted to a central database through CHIA, which can be utilized and expanded. An APCDR must include these as well as other claim types, such as individual practitioners (e.g., physician, dentist, therapist, etc.), ancillary claims (e.g., pharmacy, laboratory, etc.), long-term support and services claims, and others.

Another existing Nevada resource is the health registries and data that exist within the state's public health system. Work is already underway to connect this public health data with the existing hospital claims data at CHIA. While these efforts will create more robust access to data, this enhancement will not include access to true clinical quality outcome data, which will require access to data that currently resides in the providers' EHRs.

The implementation of APMs promotes participation by individuals and entities that have not traditionally been members of care teams. For example, care coordination activities of PCMHs and MHHs can include outreach to agencies providing relief for social determinants of health, such as TANF, WIC, SNAP and other social services.

These non-traditional entities collect information about the members they support. Through SIM initiatives, mechanisms to leverage this information for purposes of measuring population health improvements will be developed. In addition to the agencies providing social services listed above, datasets outside the traditional health care setting that can be utilized to measure success of SIM efforts also include annual reporting to federal authorities, such as the Department of Education and the Department of Justice.

The CHIA database, public health data, other agency data and other public datasets can be utilized to monitor the SHSIP efforts. Other public data sets include, but are not limited to:

- Behavioral Risk Factor Surveillance System (BRFSS)
- U.S. Census Bureau
- America's Health Rankings
- The Henry J. Kaiser Family Foundation State Health Facts
- Bureau of Labor Statistics

Nevada also will administratively support greater transparency by providing public-facing dashboards and routinely updated reports. These tools will be used to share the status of Nevada's population health and related health care metrics with the public, eventually providing this data at an aggregate level and subdivided by payer, geographic area and at other demographic levels. In addition to providing greater transparency, this data will be helpful to public health officials, researchers and the PHIC.

Provider Domain

Providers have consistently communicated that in order to achieve improved outcomes and decrease cost they must have access to current, complete and actionable patient data. Furthermore, if providers will be reimbursed based on the outcomes of the populations they treat, technical applications need to exist to permit the provider to know how well they are progressing toward those value-based reimbursement targets. Stakeholders have advised

that they are not inclined to visit a different website or portal for every payer. Development and deployment of a centralized provider portal that reflects the provider's performance at an aggregate level, as well as by payer, is planned. Furthermore, the portal will assist the provider in identifying gaps in care and actionable steps to resolve those gaps. To ensure this tool includes the ability to measure outcomes, connectivity to a robust statewide HIE is required.

Patient Domain

HIT enhancements are planned to support increased patient engagement and health literacy. To support the providers' attempts to empower and motivate patients, the development and deployment of a patient portal is planned. The patient portal will include educational information regarding disease states, prevention, wellness and general health topics. The portal also will include a portable health record that will permit patient access to centralized information regarding their health, treatments and other health information. This portable health record will follow the patient's relationship with the payer and follow the patient-not the payer. The patient will be able to grant access to the health record to the health care provider or authorized representative. The patient portal is planned to be adaptive to the known history of the patient and will identify key disease states or gaps in care for that individual upon login by prompting the patient to take action or engage in actions or online educational topics that are relevant to their condition and needs.

Based on thorough analysis of the current HIT needs, the HIT and Data Taskforce consensus was reached that the following HIT elements must be implemented to support the future transformed delivery system:

- Statewide adoption of the HIE
- Population health analytics tool
- Provider HIT technical assistance
- Public-facing dashboard and reporting portal
- Patient portal to Personal Health Records
- Creation of an APCDR

These elements and their utility to support value-based payment and delivery system reform are further described in *Section VI*.

D. Strategies

Phased-In Approach

Moving from the current HIT environment to the envisioned future environment will require infrastructure, funding, buy-in legislation and time. Thus, a phased-in approach was offered and adopted by the taskforce. This phased-in approach included a short-term and long-term strategy.

Short-Term Strategy

Phase I will leverage the Quality Reporting Data Architecture (QRDA). Specifically, Nevada will use the Health Level Seven (HL7) QRDA III standard structure for reporting aggregate quality data from individual providers for electronic Clinical Quality Measures (eCQMs). "QRDA III quality reporting gives organizations the statistical information needed to track diseases, monitor quality of health care delivery, track the results of particular measures over time and determine results from specific populations for those measures. Using quality query systems, researchers can ask questions of the data residing in health information systems and receive relevant data that are stripped of all patient identifiers, protecting patients and health care providers from the risks of inadvertent privacy loss."[lxiii] QRDA III has been adopted as an electronic reporting format for eCQM submission for purposes of meeting MU. As such, utilizing QRDA III should not present an undue burden to providers.

As part of this short-term solution, providers will submit QRDA III reports to the participating payers to establish a baseline for population health and then periodically to assess improvements at the payer level. The PHIC will undertake a discussion regarding the potential formation of a centralized clinical registry to receive the QRDA III information across all payers instead of provider submission to individual payers. A centralized clinical registry would permit administrative oversight of the SHSIP implementation effects by allowing a tool to query quality reporting across all submitting providers and all payers.

The QRDA III reports offer benefits but also come with some limitations. Benefits include:

- QRDA III data are in an industry-accepted format
- Providers meeting MU requirements already have the ability to produce QRDA III reports
- No patient identifiers are present, which overcomes privacy concerns
- QRDA III provides a low-barrier pathway to accessing outcome data

Limitations of using the QRDA III in this manner and for this purpose include:

- Patients may be represented in more than one provider's QRDA III report
- Stratifying outcomes by acuity level, individual provider population risk level or patient demographics is not achievable
- Outcomes are not measurable by payer for incorporation into value-based payment methodologies
- No clinical registry to collect this data exists today
- A tool to query the clinical registry would have to be developed or procured

Long-Term Strategy

The long-term HIT strategy for Nevada includes incorporating the future components identified by the HIT and Data Taskforce as discussed above. These include:

- Expanding the statewide HIE
- Maximizing the use of existing data and registries
- Creating an APCDR
- Introducing a population health analytics tool
- Creating a role-based portal for providers, patients, the public and administrative purposes

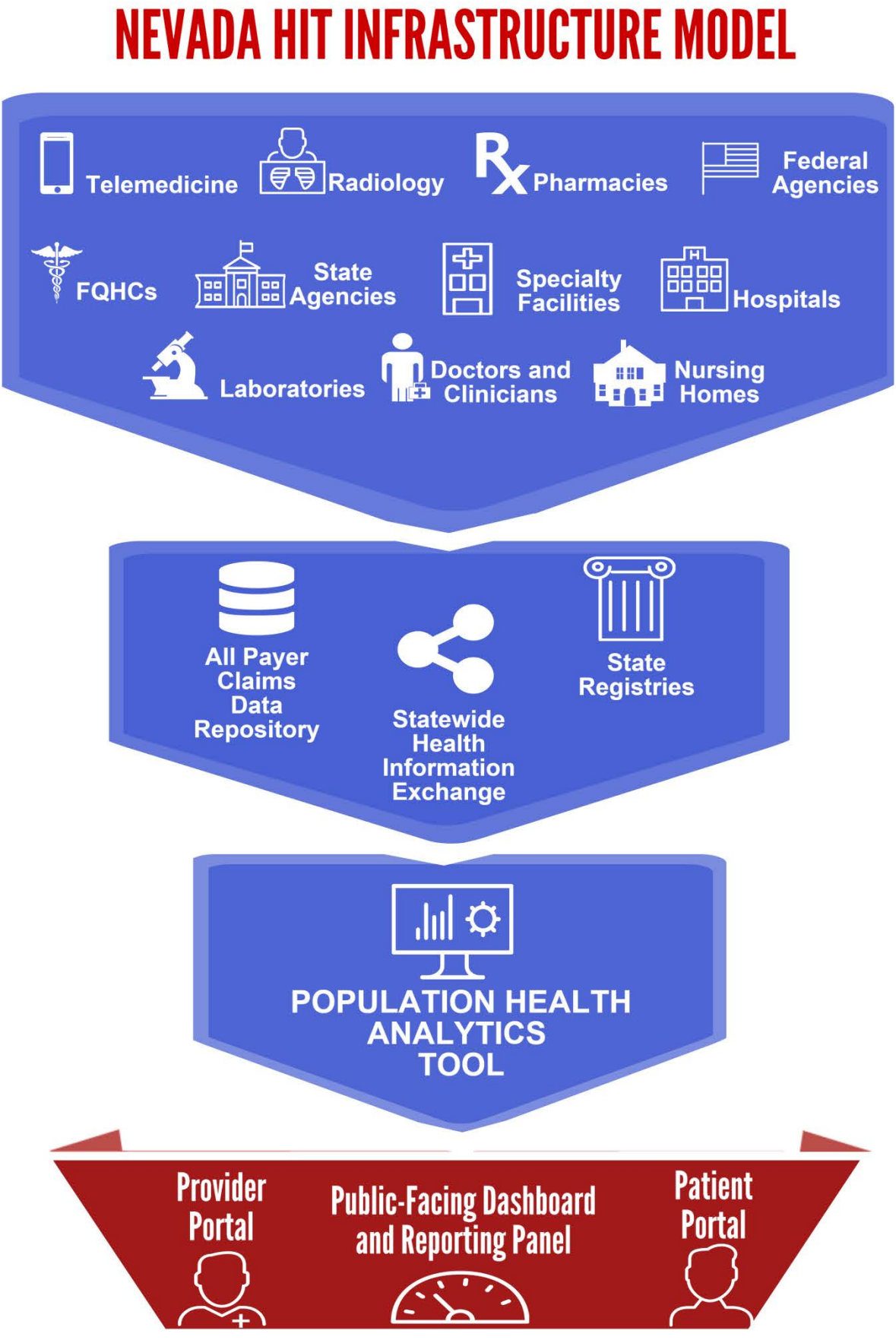
The planned APCDR will be linked with a strengthened statewide HIE and supplemented with public health registries. Where appropriate, other state databases that may be relevant to influencing or evaluating health outcomes will be linked to the APCDR, HIE and public health registries' data.

These building blocks will be accessed by a population health analytics tool that aggregates the data and provides meaningful information to a variety of audiences regarding population health. The population health analytics tool will promote information to the physicians, other providers, patients, payers, researchers and the public as described above. It also will provide information to the DHHS and the PHIC in assessing population health.

While described separately, each of these audiences will access this information via a single roles-based portal. Creating one portal that is a roles-based system will be manageable in maintaining an environment that can support a wide variety of users and their needs.

A visual representation of the proposed HIT infrastructure is depicted in *Figure 18*.

Figure 18: Proposed Nevada HIT Infrastructure Model



Supporting Strategies

State HIT Coordinator

Through the SIM process, Nevada has identified a need for additional HIT leadership to support HIT initiatives for the SHSIP as well as for Medicaid administration purposes. As a result, the state plans to reinstate the State HIT Coordinator position to champion and lead HIT initiatives for the state. This position also will serve as the technical liaison between the executive sponsor (DHHS) and the PHIC and will oversee the day-to-day development and deployment of the Nevada SIM solution. Since the position also will serve the Medicaid enterprise, the position will be housed in the Medicaid agency with responsibility for managing coordination across the relevant state agencies. While the HIT Coordinator position is vital to leading HIT initiatives, Nevada anticipates the need for support staff and resources to support the deployment of these projects in areas including, but not limited to:

- Data analytics
- Medicaid EHR incentive payment program support
- Public health
- Social determinant data studies
- Strategy and planning (including sustainability)
- Provider/patient engagement

Nevada will use enhanced Medicaid funding (90 percent federal/10 percent state) to support the Medicaid share of these needs and use other state funds and work with private payers or other funding sources to finance the remaining share of these costs. Reinstating the HIT Coordinator position and receiving the enhanced federal match requires an addendum to Nevada's State Medicaid Health Information Technology Plan (SMHP) and submission of an Implementation-Advanced Planning Document Updated (I-APDU). The addendum to the SMHP and the addition of more staffing and resource support are considered top priorities in 2016.

HIE Onboarding

The HIT Taskforce noted one of the barriers accounting for lack of HIE adoption was the cost to connect providers to the exchange. The state intends to use the enhanced federal funding to connect Medicaid providers for the purposes of the MU Program. While this covers a large share of the provider community, alternate funding (i.e., an assessment on claims, or voluntary payer contributions to a shared system) will be required to help connect the non-Medicaid MU providers. These onboarding initiatives will adhere to CMS requirements found in the guidance at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/federal-financial-participation-for-hit-and-hie.html.

As past HIE onboarding shows, the reality is that providers must actually use the HIE. The information that is accessible through the HIE will serve as a key tool to permit providers to achieve improved outcomes and better population health. Tying reimbursement incentives to outcomes and population health, as described in the Payment Transformation section (*Section VII*), is expected to improve provider contribution and use of the HIE.

REC-like Services

Nevada plans to conduct landscape surveys for both SIM and the Medicaid EHR program to determine providers' and hospitals' HIT capabilities, planned HIT utilization/adoption for MU, and experience/readiness in value-based reimbursement models. Nevada also will provide technical assistance to educate providers on the use of HIT and the HIE; help providers adopt, implement and become meaningful users of EHRs; while utilizing the HIE to support value-based payment adoption. A key REC function that providers have voiced through the stakeholder process is technical assistance with integrating EHR functionality within practice software and routine business operations.

E. Governance

The governance for Nevada's HIT plan deployment will include responsibilities of the PHIC and the DHHS leadership. The DHHS leadership will seek and require input from the PHIC and any relevant committees formed under that Council. The DHHS will ensure alignment of the SHSIP HIT plan execution with the updated SMHP. With assistance from the State HIT Coordinator, the DHHS will strive to leverage the utilization of federally available enhanced funding to accomplish the goals and objectives of the plan.

F. Approach and Timeline

Within the first three months of SHSIP implementation, the PHIC will provide recommendations and advice to the DHHS regarding the short-term strategy to collect outcomes data and mechanisms to assess population health baseline as well as progress measurements. Should the recommendations include costs, the PHIC also will explore and present financing options to the DHHS. The DHHS will authorize the proposed approach or return the strategy back to the PHIC for their further review and revised recommendations.

Work also will begin during the first calendar quarter of 2016 to refine the long-term HIT solution. Through the model design work, the HIT and Data Task Force has completed the data asset inventory, defined high-level business needs, developed a conceptual model of the desired solution, and identified an immediate governance strategy. This effort charts the high-level strategic direction. Many details must be identified and defined to make operational the long-term HIT strategy. Once a source of funding and sustainability is identified, Nevada plans to release a Request for Information (RFI) to gain potential vendor and interested party feedback on the conceptual model and potential solution. This RFI will build upon the knowledge obtained through the HIT and Data Taskforce and develop a deeper level of detail regarding the HIT components, features and requirements. This feedback and detail will be incorporated into a Request for Proposal (RFP) to procure a vendor to deliver the HIT technical solution.

The RFI and RFP process defined above will shape and refine the final approach. However, the long-term HIT solution is envisioned to have multiple phases before all components described in the HIT Plan's "HIT Needs and Future Components" are implemented. The combination of this long-term phased-in strategy in conjunction with a more immediate short-term solution will permit Nevada to initiate the SHSIP, which will create a multi-year road map to identify, implement and refine a SIM HIT plan that supports statewide health

care delivery and payment transformation efforts. *Figure 19* illustrates a potential HIT timeline.

Figure 19: HIT Timeline

Start Date	Completion Date	Action	Purpose/Comments
1Q2016	2Q2016	SMHP Addendum	Addendum will introduce staffing needs for HIT Coordinator
1Q2016	2Q2016	Submit HIT I-APDU	Starts after SMHP update approved and requests funding for HIT Coordinator
1Q2016	2Q2016	Secure a State HIT Coordinator	Requires approved I-APDU
February 2016	April 2016	Identify funding sources and sustainability for SIM HIT technical solution	A source of funding must be identified to move forward with the HIT Plan
February 2016	May 2016	Develop and release a Request for Information (RFI) for SIM HIT technical solution	Gain potential vendor and interested party feedback on conceptual model and potential solution
June 2016	June 2016	RFI response due	The RFI is planned to be open for 30 days
July 2016	October 2016	Utilize RFI responses to formulate a Request for Proposal (RFP) for the proposed HIT technical solution	Refine the conceptual model and potential solution requirements and start procurement process for the SIM HIT technical solution
November 2016	November 2016	Release SIM HIT technical solution RFP	Competitive procurement for the HIT solution
February 2017	April 2017	Evaluate SIM HIT technical solution RFP responses	Identify successful vendor
May 2017	June 2017	Contracting activities	Negotiate and execute contract with successful vendor
July 2017	December 2017	Design and development	Requirements analysis, technical design and testing
January 2018	January 2018	Implement the SIM HIT Technical Solution – Phase I	Solution will be phased-in with APCDR being last.

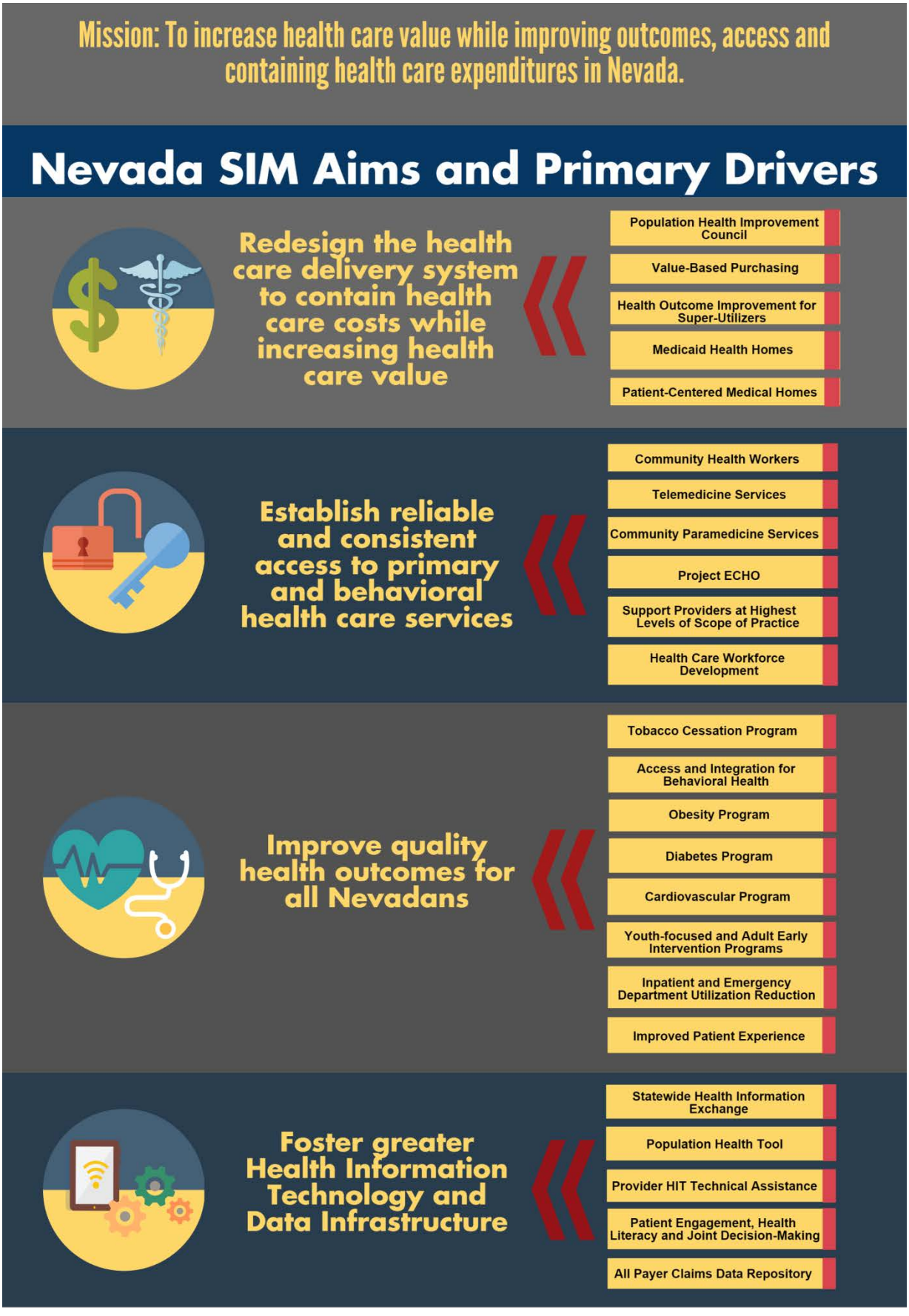
VI.DELIVERY SYSTEM TRANSFORMATION

Through the process described in the Project Approach section, assessment of the current Nevada health care delivery system was performed and a vision for a future health care delivery system was discussed among the engaged stakeholders. This stakeholder-driven process arrived at four primary aims that the SHSIP must address. These aims called for:

- A redesign of the Nevada health care delivery system to contain health care costs while increasing health care value
- Establishing reliable and consistent access to primary and behavioral health care services
- Improving health outcomes for all Nevadans
- Fostering greater HIT and data infrastructure to support the much needed delivery system and payment transformation initiative

Figure 20 provides the Nevada SIM driver diagram with the four aims and primary drivers.

Figure 20: Nevada SIM Driver Diagram



A. Driver Diagram

AIM: Redesign the health care delivery system to contain health care costs while increasing health care value

The primary aim of Nevada is to redesign the health care delivery system to contain costs while increasing health care value. The current state of health care is unsustainable and requires change. Paying more for health care without improving health outcomes is not feasible.

This significant undertaking requires leadership, coordination and care models seeking to improve population health, while providing improved care for individual patients. The primary drivers for reaching this aim strive to address these factors.

1. Establish the PHIC to support and monitor statewide achievement of SIM Aims.

Several keys to successful delivery system reform include enabling effective planning and stakeholder engagement, effective coordination and support of common goals, developing strong data infrastructure and quality measurement methodology, and developing financial and payment methods that support these goals.

In particular, three core components are considered essential for successfully integrating health and social services. These core components are a coordinating mechanism, quality measurement and data-sharing tools, and aligned financing and payment methods. The Nevada plan addresses each of these. The first is addressed through this primary driver.

Key responsibilities of the coordinating mechanism, referred to as the "system integrator," are to offer leadership, communication among various state and community levels, and decision-making across all participating institutions.[lxiv] This leadership body allows for a common platform to build engagement and support but that further allows for important executive resolution so issues are not allowed to stagnate, to be left unclear or to go unanswered.

The body implementing the SHSIP under the oversight and approval of the DHHS leadership is the PHIC. The PHIC will be responsible for championing the aims of Nevada and guiding the successful actions and accomplishments of the corresponding primary and secondary drivers that will enable achievement of Nevada's aims. These activities will be performed under the overarching guidance of the DHHS leadership.

High-level goals of the PHIC and its supporting committees will include, but may not be limited to:

- Ensuring the perspective of providers, payers, state agencies, consumers/advocates and other stakeholders are represented
- Identifying Nevada population health priorities and focus areas
- Developing population health improvement strategies that can be applied across multiple payers

- Promoting pooled payer resources and the identification of other funding sources to achieve the objectives of the SHSIP
- Supporting cross-payer alignment on key delivery system, payment and health program models
- Providing support on the approach to provider practice transformation
- Developing a standard but flexible VBP approach and support adoption
- Establishing pay-for-performance improvement goals
- Establishing timelines for adoption of PCMH framework
- Agreeing to established performance measurement parameters for simplified reporting and accountability
- Supporting training and resource sharing to aid provider practice transformation success

The DHHS will oversee implementation of the transformation plan until the DHHS can evaluate whether transfer of day-to-day administration of the effort to the PHIC would best support the plan. If handoff is determined appropriate by the DHHS, transition will only occur after a comprehensive transition strategy has been developed. The full transition may take place over the course of several years.

The PHIC will bring together state agency staff, public health experts, payers, providers, employers, consumers/advocates and other stakeholders in the state who have shared interests in the aims of Nevada, as outlined in the SHSIP. This body will be charged with reaching consensus on basic elements regarding outcome measure methodology, targeted improvements and provider payment models to meet Nevada's aims. The PHIC will make decisions regarding the infrastructure and IT solutions needed for providers to perform under the initial provider payment models, and determine how the state will support the adoption of the identified functionality.

The underlying principle behind the creation of the PHIC is that true payer and provider buy-in requires a voice in the decision process. With this collaboration in mind, the PHIC also will work closely with the advisory group that will be established by the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease as required by SB6, which shares related objectives.

It will be important for the PHIC to have strong commitment from all parties. This commitment will be captured through an agreed-upon mission statement and operating principles in the form of a charter document to be signed by each participant.

The PHIC will be supported by designated workgroups or committees with targeted expertise. The quality committee, including providers and payers, is expected to mutually explore delivery system models, health outcome objectives, targeted population health improvement goals and unified communication regarding expectations. The MPC brings together participating payers and is responsible for reaching consensus on payer

approaches and supports regarding SHSIP and population health initiatives. The financial alignment workgroup will develop the common structure of the value-based reimbursement program and look for opportunities to improve existing models and ensure provider concerns are evaluated and incorporated, and that the value-based reimbursement methodologies evolve.

Equally important is acknowledging the limitations on the scope of the PHIC responsibilities and authority. Stakeholders have acknowledged both the need for as much commonality across involved payers, and the reality that payer involvement will depend on their ability to maintain some degree of autonomy. Therefore, the PHIC will strive toward commonality regarding statewide priorities, endorsed clinical practice guidelines, national metrics that will be used to evaluate outcomes and key structural components of value-based reimbursement. Payers will maintain some degree of flexibility in their business rules and processes to fine-tune plan-specific requirements.

Planned Actions (Secondary Drivers and Metrics)

- Monitor execution of VBP alignment strategies (e.g., pay for performance, bundled payments, alternative payment models [APM], etc.). By Q1 2016, the PHIC has met and confirmed at least four payer participants. In addition, the PHIC has developed a mission statement.
- Review and secure support for innovative service delivery models (e.g., super-utilizers, PCMHs, etc.) By Q1 2016, the PHIC has reviewed various service delivery models and secured support for identified models.
- Develop a Strategic Technical Assistance Team (STAT) model that makes time-limited staff available to providers for on-site training and resource sharing to support practice transformation success. The PHIC will guide the development of the STAT, including skill set, focus areas for assistance, funding and sustainability. By Q4 2017, on-site training and resources will be available for deployment.

2. Increase the use of value-based purchasing (VBP) (e.g., pay for performance, bundled payments, APMs, etc.) in the state by all payers to improve acceleration and adoption of meaningful delivery system reform.

Provider reimbursement models have traditionally rewarded providers for the volume of services provided. Alternatively, VBP models are payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost.

The transition to value-based reimbursement systems seeks to reimburse providers for outcomes of care rather volume of services and is a key component of the Nevada SIM efforts. Reimbursement for outcomes will be measured at a provider's population level versus on an individual patient level which expands and connects each provider visit to the larger health care landscape. Such a reimbursement paradigm shift requires payers and providers to work together in ways that largely have not been considered in the past. This collaboration is especially crucial for patients with more than one source of health insurance coverage and for patients that cycle between public and private coverage. Additionally, a

preponderance of payments based on value creates an economic incentive for providers to invest in needed infrastructure to achieve high-value performance, such as technology to support comprehensive care coordination.

As Nevada implements these initiatives, the adoption of HIT will be foundational to the success of the projects. It will be important to ensure stakeholders fully understand how (1) meaningfully utilizing electronic health records that have the capability to generate quality measures, (2) developing connections within organizations and between entities to share evidence-based practice protocols, and (3) having connectivity to a functional HIE, support alternative payment methodologies and the evaluation of population health improvements. Developing a system where providers can share patient information at critical patient care decision points is a benefit of an integrated information technology infrastructure because it allows for improved coordination of care by:

- Enabling critical notifications to care teams when patients are admitted, discharged or transferred
- Supporting the development of comprehensive treatment plans
- Monitoring referrals to other social services

As a result of leveraging funding opportunities related to HIT and other CMS initiatives, as well as endeavors supported by the PHIC and MPC, Nevada anticipates significantly increasing the usage of VBP models by the end of 2018.

Planned Actions (Secondary Drivers and Metrics)

- Align private and public VBP models that are already in place. By Q2 2016, payers have adopted a framework for key components of VBP as approved by the MPC, including how the components are to be communicated to providers.
- Explore VBP approach in payer contracts with health care vendors. By Q4 2016, all MPC payers have reviewed and updated downstream contracts for opportunities to institute VBP alignment.
- Increase the usage of innovative VBP models. By Q2 2016, each MPC payer has reported, as a baseline, the percentage of VBPs, either by percentage of claims or patients. By Q4 2018, the payers have increased baseline VBPs by 20 percent. For those providers with less than 20 percent VBP at baseline, a goal of not less than 20 percent is established.

3. Develop and align programs to manage and improve health outcomes for super-utilizers of the health care system across payers.

During the stakeholder engagement process, meetings were held with a number of hospitals, health care professionals and other parties. Concerns were communicated regarding the Nevada population who unnecessarily and chronically use the ED as a routine source of care. While the ED is a common site of care for these individuals, their utilization

is not limited to the ED. Some patients accessed care in traditional settings, but usage was excessive compared to what would be appropriate with better coordination of care.

National estimates suggest that the top 1 percent of health care utilizers cost 25 percent of total health care spending, at a cost of $100,000 per member per year.[lxv] The overall average annual spending for the overall population is only $3,837. More than three-quarters (77 percent) of the 1 percent have at least one chronic condition. The top 5 percent make up 50 percent of health care spending. To offer an additional comparison, the highest 1 percent of individuals with diabetes utilizing health care services costs on average $102,465 while the average individual with diabetes only costs $11,858 annually.[lxvi]

High cost utilizers are not limited by payer source. These super-utilizers cross all payers and demographics. Patients known as “dual eligible” with both Medicare and Medicaid coverage cost $19,418 on average compared to $8,789 for the average Medicare-only beneficiary. Medicaid defines beneficiaries with complex needs and high costs as beneficiaries who: are likely to experience high levels of costly but preventable service utilization because of their health and/or social conditions, and whose care patterns and costs are potentially “valuable.” These subsets of beneficiaries are an extremely heterogeneous group with varying medical, behavioral and psychosocial needs.[lxvii]

Targeting cost-saving initiatives based on high levels of spending alone is often a flawed approach. High levels of spending in the absence of excessively high rates of inpatient or outpatient care is often simply a marker of legitimate and necessary medical treatment for a high-cost condition, making it a poor targeting criterion (by itself) for super-utilizer programs aiming to reduce unnecessary use of medical resources.[lxviii]

An increasing number of programs are being developed to care for these patients in highly unique ways to impact their care in a positive way. Research has found that effective super-utilizer programs can reduce readmissions, hospital lengths of stay, the number of ED visits, total cost of care and improve outcomes.[lxix]

Particular attention must be paid to this distinct population. Information published by the Center for Health Care Strategies suggests that programs with specialized care teams that develop assessments, employ care plans and coach patients are factors found to be valuable. For these patients, examining social needs such as housing and food security also play a vital role.[lxx] This focused effort can achieve impressive cost savings and improved quality, as found in piloted efforts. A notable example is the Camden Coalition’s Link2Care – Camden Care Management Program for super-utilizers, which decreased admissions by 57 percent per month, decreased ED visits by 33 percent and decreased costs of care (incurred charges) by 56 percent.

For these reasons, Nevada will develop a common definition of a super-utilizer through the collaboration of the PHIC to identify and treat those individuals with core treatment methods. These core methods include ensuring that all super-utilizers are assigned a PCP, a care team and have a treatment plan in place. Targeted approaches will be identified to coordinate care and conduct outreach and engagement to continue to coach and support

these individuals to manage their health care more effectively. These approaches may include the expansion of HIT infrastructure to support comprehensive case management.

Planned Actions (Secondary Drivers and Metrics)

- Work across payers to align the identification and interventions targeting high utilizers of care to ensure that there is at a minimum an assigned PCP. By Q2 2016, the PHIC payers have developed the formula for identification of super-utilizers. By Q3 2016, 95 percent of super-utilizers are assigned to a PCP.
- Ensure a care team is in place for identified super-utilizers. By Q1 2017, 80 percent of super-utilizers are assigned to a care team.
- Ensure a treatment plan is in place for identified super-utilizers. By Q1 2017, 80 percent of super-utilizers have a treatment plan in place.

4. Develop Medicaid Health Homes.

The Nevada transformation plan will incorporate the development of an MHH model as permitted under Section 2703 (*State Option to Provide Health Homes for Enrollees with Chronic Conditions*) of the Patient Protection and Affordable Care Act. This section of the Act establishes a health home for low-income adults with two or more chronic diseases or individuals with one chronic condition and at-risk for a second, or a serious and persistent mental illness. These characteristics are often observed in the high utilizer population discussed by the Nevada stakeholders.

Stakeholders generally agreed that the population included in the MHH model should be consistent with the CMS definition as, "beneficiaries with complex, unaddressed health issues and a history of frequent encounters with health care providers."[lxxi] Like the statistics described above, CMS has stated that one percent of the Medicaid population accounts for 25 percent of total Medicaid expenditures and 83 percent of this 1 percent have three or more chronic conditions with 60 percent having five or more conditions.[lxxii] For these reasons, the target population for inclusion in the health home for Medicaid beneficiaries will initially be those with complex chronic conditions, and later the severe and persistent mental illness populations will be targeted for inclusion.

Because Section 2703 authority has predefined patient characteristics, and encompasses only a single payer type, this program may be differentiated from, but should complement, the multi-payer super-utilizer program developed. Successes and lessons learned from the MHH model will be shared with other payers for consideration of model replication in the nonpublic payer programs in the state.

The core focus and services provided by the Nevada MHHs will include, but may not be limited to, comprehensive care management and care coordination, increasing patient involvement in their health care, transitional care and follow-up (especially transition from inpatient to outpatient settings), delivering patient-centered and family-involved care, and a holistic approach to linking individuals to community and social support services that stands to contribute to improved health status and resolves health inequities.

The Nevada MHH model will recognize designated providers, a team of health care professionals or a health team consistent with CMS guidance on health homes. Under this guidance, designated providers may include:

- Physician
- Pediatrician
- OB/GYN
- Clinical/group practice
- Rural health clinic
- Community health center
- Community mental health center
- Home health agency

Other providers will be considered on a case-by-case basis, evaluating the needs of the individual and the credentials of the provider willing to serve as the nucleus of the health home. A designated team of health care professionals may include:

- Physicians
- Nurse care coordinators
- Nutritionists
- Social workers
- Behavioral health professionals
- Freestanding, virtual, hospital-based providers

Health teams may include:

- Medical specialists
- Nurses
- Pharmacists
- Nutritionists
- Dieticians
- Social workers
- Behavioral health providers
- Chiropractors
- Licensed complementary and alternative practitioners[lxxiii]

The federal flexibility of what can constitute an MHH is particularly important in Nevada given provider shortages and access issues.

Implementation of the MHH model is anticipated to be phased in. Feedback from stakeholders included that the Medicaid expansion population with severe behavioral health needs has the greatest need for health home support and opportunities for cost savings. This population is being considered as an early inclusion in the model. After implementing this population, attention will turn to other populations, which at a minimum are expected to include those non-expansion individuals with a serious and persistent mental illness (SPMI).

Challenges are anticipated to the health home model's success. As with PCMH deployment, access to providers who are willing to serve as the nucleus of the health home may be problematic. The state's shortage of physicians and physician-to-patient distribution across the state will prove challenging as will the shortage of specialists. Furthermore, forming a multidisciplinary team of health care professionals committed to serving this complex and vulnerable population may prove difficult. Both the shortage of health care professionals in the state and the rural and frontier nature of the state have created the need to ensure health care professionals are operating at the top of their scope of practice and that existing resources are properly leveraged. Therefore, the use of virtual health homes and the use of telehealth technology may be necessary. Linking PCPs with specialists through Project ECHO expansion will be important as well.

Another challenge with deploying the MHH model is ensuring that no services are duplicated by existing or new programs. Specifically, the Medicaid FFS population already receives care management and coordination services through a third-party vendor, which is contracted to provide a multidisciplinary team to address the needs of individuals with complex, chronic conditions through the Nevada Medicaid Health Care Guidance Program (HCGP). This program operates under an 1115(a) waiver providing support to certain patients with chronic conditions. Incorporation of the MHH will have to be accomplished in a manner that reinforces the goals of the PCMH and health home models without duplicating the HCGP efforts. Potential duplication of services also will have to be reviewed under the State Plan to ensure there is no duplication of services under the Medicaid agency's existing Targeted Case Management (TCM) activities.

Additionally, the Medicaid population residing in Washoe and Clark counties is currently included in the state's Medicaid MCO program. The Nevada MCO vendors provide care coordination and care management services. Final design elements that are separate but complementary to the existing MCO program must be identified to ensure no duplication of services.

Planned Actions (Secondary Drivers and Metrics)

- Address duplication of service issues between delivery models. By the end of Q1 2016, the Medicaid program will review care/case management services across PCMH, MCO and other program models to define the requirements for each model thereby reducing duplication of services.
- Develop a Nevada MHH monitoring plan and reimbursement model that complements the PCMH model. By Q2 2016, the Medicaid program has defined the monitoring plan and determined the formula for identification of MHH patients. By Q2

2017, the federal authority and infrastructure to implement the MHH has been secured. By Q1 2018, all individuals enrolled in an MHH have been assigned to an actively engaged PCP monitoring the patient's treatment.

5. Increase the number of Patient-Centered Medical Homes.

The transformed Nevada health care delivery system will encourage a PCMH model to improve care coordination, patient engagement and improve outcomes. Expanding the number of provider practices recognized by NCQA as PCMHs or operating under PCMH principles will provide the foundation for improving individual health as well as population health.

Nevada will recognize five key components to a PCMH:

- ***Comprehensive Care:*** Primary care teams are developed to offer greater support to the patient. These teams can be made up of providers, such as nurses, pharmacists, dieticians, social workers and/or psychologists.
- ***Patient-Centered:*** Facilities ensure that treatment engages the patient in their care through shared decision-making, as well as focus on treating the whole person versus solely an acute or chronic condition without respect to the person's full physical and mental well-being.
- ***Coordinated Care:*** The PCMH practice exchanges treatment information and supports the broader health care system, including specialty care, hospitals' home health care and community support services. This allows the patient to have improved transitions of care among other benefits.
- ***Accessible Services:*** An important factor to managing care outside of the ED. PCMH practices ensure that patients have access to care after hours, online and for urgent care.
- ***Quality and Safety:*** Variability in the delivery of health care services is one of the most common and unsafe practices in health care today. The PCMH practice is committed to using evidence based medicine and clinical decision-support tools to provide the highest quality of care. The PCMH practice uses technology to monitor population health of assigned patients to ensure that preventive screenings and health assessments are conducted.

The development and maintenance of the PCMH model will not occur overnight. Expanding and supporting this model through incentive payments will allow additional providers to routinely offer high quality, coordinated care. Stakeholders have suggested that a plan be developed to help support those providers not currently possessing NCQA recognition, but who have an active plan to achieve recognition within a certain time period.

Increasing the percentage of Nevadans connected with PCMHs has a number of advantages. PCMHs provide a source of continuous and integrated care that stands to produce improved health outcomes and decrease unnecessary health care expenditures. Advantages offered by this model include improved quality of care and health outcomes,

greater patient-provider engagement, decreased hospitalizations and ED utilization, and a reduction in health care disparities. This expectation is supported by national literature as demonstrated in the following referenced evidence:

- PCMHs cut the growth in outpatient ED visits by 11 percent over non-PCMHs for Medicare patients[lxxiv]
- PCMHs lower total cost of care for Medicare FFS beneficiaries: Medicare claims and enrollment data[lxxv]
- PCMHs lower costs and provide a high ROI[lxxvi, lxxvii]
- PCMHs provide more effective care management and optimize use of health care services[lxxviii]
- PCMHs reduce socioeconomic disparities in cancer screening[lxxix]
- Multi-payer PCMHs reduce preventable ED visits[lxxx]
- Medicaid PCMHs increase patient access and lower inpatient admissions and Per Member Per Month (PMPM) costs through state PCMH initiatives[lxxxi]
- PCMHs increase rates of quality improvement[lxxxii]
- PCMHs produce the most effective cost savings in highest risk patients[lxxxiii]

A significant challenge to achieving statewide PCMH connectivity is access. Due to the rural and frontier nature of the state, there are challenges with merely securing access to a physician. Additionally, there are relatively few NCQA recognized PCMH clinicians in Nevada. These existing PCMH clinicians are not evenly distributed across the state in proportion to population density.

Providers and representatives of physician associations participating in the stakeholder meetings discussed challenges they faced in achieving certification as a PCMH. These stakeholders stated that gaining the support of leadership was foremost to the success of the medical home initiative. They found that the implementation process was best achieved when key decision-makers supported the practice transformation. To gain this support, leaders were presented with research findings and statistics showing the impact that PCMHs can have in improved quality, greater patient engagement and reductions in avoidable hospitalizations and use of emergency rooms for primary care. In a report by the IBM Institute for Business Value, authors Jim Adams, Paul Grundy, M.D., Martin S. Kohn, M.D. and Edgar L. Mounbi state, “All medical homes initiatives face common implementation issues despite differences in approach and focus.”[lxxxiv] The most common issues they cite are as follows:

- The need for adequate incentives for primary care physicians to participate
- The risk that limiting the members and patients to a target population will lead to unnecessary complication and confusion for practices
- Initial funding for a PCMH initiative is a substantial investment

- A governance structure should be inclusive of all relevant stakeholders across the public and private sectors
- Identifying the right key measurement and evaluation processes because of their effects on the rewards
- Finding the right balance of four basic reimbursement elements: FFS payments with new service codes, care management fees, bonus payments for meeting certain criteria, and quality or performance incentives
- Challenges faced with change management, including the redesign of key processes and capabilities, as well as changes in roles and responsibilities, and cultural change
- The need for fully functioning, secure interoperable EHR systems with decision support capabilities, as well as other IT-related capabilities, such as e-prescribing, quality reporting, patient portals, online appointment scheduling and connectivity to an HIE
- The need for a mechanism to accurately and seamlessly match each patient to a primary care physician and a health plan, making sure the primary care physician has a large enough panel, and avoiding the risk of "cherry picking" patients
- Sustainability of the pilot implementations could be challenged by a number of factors, such as funding issues, or resistance from key stakeholders

Therefore, the use of PCMHs as part of a transformed health care delivery system will require practice transformation support and fiscal incentives for providers to achieve and maintain PCMH status. The MPC can play a key role in mitigating the anticipated barriers by identifying mechanisms to decrease the administrative burdens discussed above, developing appropriate payment infrastructure, and the support of HIT to drive provider collaboration, care coordination and patient engagement. Finally, connecting Nevadans with PCMH practices may require the use of telemedicine or the creation of virtual PCMH practices, which will partner non-PCMH providers with NCQA recognized practices.

Planned Actions (Secondary Drivers and Metrics)

- Develop an aligned PCMH program and reimbursement model that may include tiered PMPM, quality incentive and infrastructure support. By Q3 2016, the MPC has agreement on the PCMH model. By Q2 2017, the PHIC payers have reimbursement approaches in place and have made 100 percent of initial incentive payments for all components.
- Determine key elements of the PCMH delivery system model, including attribution, provider directory management and measurement. By Q4 2016, the MPC has agreement on key elements of the PCMH model, including attribution, provider directory management and performance measurement.
- Develop technical assistance to support provider practice transformation and PCMH recognition. By Q4 2016, the PHIC payers have developed a technical program to support the goal of increasing the percent of PCMH providers.

AIM: Establish Reliable and Consistent Access to Primary and Behavioral Health Care Services

In the second aim, Nevada seeks to improve access to primary and behavioral health care services. Nevada wants to ensure that access to care is reliable and consistent statewide. The current challenges in Nevada related to provider access are critical concerns that must be addressed to impact the overall health care system. Methods to increase access include more than the addition of PCPs. It includes such enhancements as expanding use of new paramedical professionals to support a patient's understanding and navigation of the system, as well as advancing technology to support providers at the point of care. Efforts to address these needs, as described below, will be initiated to achieve the goal of ensuring reliable and consistent access to health care services in Nevada.

1. Expand and align integration of Community Health Workers in the health care system.

Nevada will add CHWs to its health care delivery system. A recurring theme heard from Nevada stakeholders is the need to assist individuals with engaging in and navigating through the health care delivery system. This concern was said to be most needed with the Medicaid expansion population. The Nevada health care delivery system transformation plan calls for expanding the CHW program in Nevada.

CHWs are members of a local community who are viewed as trusted local resources. They are trained to serve as knowledgeable resources that help patients navigate the health care system and connect patients with community resources. According to HRSA, "CHWs usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. CHWs provide culturally appropriate health education and information, help people get the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services, such as first aid and blood pressure screening."[lxxxv]

At a national level, CHW services have demonstrated positive outcomes that include:

- Improved access to health care services
- Increased health screenings
- A better understanding between community members and the health and social service system
- Enhanced communications between community members and health providers
- Increased appropriate use of health care services
- Improved adherence to health recommendations
- Reduced need for emergency and specialty services[lxxxvi]

The PHIC via the MPC will be tasked with encouraging a reimbursement model that increases and promotes the usage of CHWs in the health care system with the goal of increasing the number of trained and employed CHWs year over year until an optimal number is reached to effectively support access to needed health care.

Planned Actions (Secondary Drivers and Metrics)

- Develop a reimbursement model for CHWs in Medicaid. By Q2 2016, Medicaid program has determined a reimbursement and delivery system model for CHWs. By Q4 2016, all MPC payers have determined an aligned reimbursement model for CHWs.
- Ensure all payers are promoting the usage of CHWs to improve care coordination and health literacy. Increase the number of trained CHWs by 25 trainees per quarter until an optimal number is reached. Increase the number of employed or utilized CHWs by 10 percent year over year until the optimal number is reached. Baseline will be determined through survey.

2. Expand and align telemedicine/telehealth program.

Growing the use of telehealth is an essential component of the transformed Nevada health care delivery system. Provider shortages in a state with such rural and frontier areas call for innovative and creative means to create access. The use of telehealth to connect patients in remote areas with specialists or health care providers who would otherwise not be accessible is a key component of the plan.

Telehealth occurs at two service sites of care. The first site of care is referred to as the “originating site.” This is the location where the patient is receiving telehealth services. The second site of care is referred to as the “distant site.” This is where a telehealth provider is providing telehealth services.

The primary concerns raised by providers as obstacles to the use of telemedicine include: lack of payer recognition of telemedicine as a billable event, investment cost of the telemedicine equipment, areas with insufficient broadband/connectivity and staffing resources needed to conduct the encounter. This method of care supports both primary and follow-up care to help alleviate the need for the patient or provider to travel great distances to receive or conduct a service. Nevada will create a taskforce to determine the current reach of telemedicine services, develop recommendations and establish additional presentation sites.

Planned Actions (Secondary Drivers and Metrics)

- Develop a taskforce for telemedicine services, ensuring that a needs assessment is conducted. By Q1 2017, a needs assessment has been conducted to determine the breadth of telemedicine and the number of additional presentation sites required to effectively improve access has been recommended.
- Establish additional telemedicine presentation sites to increase access of care. By Q4 2017, the number of recommended sites has been established.

3. Expand and align use of community paramedicine services.

Nevada will incorporate community paramedicine as an integral component of the health care delivery system. The use of paramedicine has been shown to be an effective and appropriate strategy to connect individuals with services, promote continuity of care during transitions from institutional to community settings, improve outcomes and decrease health care expenditures.

Community paramedicine has been defined as "an organized system of services, based on local need, which are provided by EMTs and paramedics integrated into the local or regional health care system and overseen by emergency personnel and PCPs. This not only addresses gaps in primary care services, but enables the presence of Emergency Medical Services (EMS) personnel for emergency response in low-call volume areas by providing routine use of their clinical skills and additional financial support from these non-EMS activities."[lxxxvii]

Planned Actions (Secondary Drivers and Metrics)

- Explore reimbursement models to support and encourage the use of community paramedicine programs. By Q2 2016, reimbursement models to support the use of community paramedicine programs will have been examined.
- Expand community paramedicine program in identified communities to support care coordination. By Q3 2016, a community paramedicine implementation road map will be made available for deployment to add and maintain community paramedicine programs, with gaps identified and goals set.
- Support and promote additional community paramedicine training. By Q4 2016, additional community paramedicine training will be supported.

4. Expand access to physician peer contacts through Project ECHO.

Project ECHO is an innovative, successful project through the University of Nevada School of Medicine (UNSOM). This initiative brings together PCPs to review individual cases with specialists on patients with like conditions. This gives providers additional support to treat complex patients based on recommendations from specialists well-versed in the latest evidence-based treatment.

This effort also offers a unique learning opportunity. Currently, Project ECHO specialists moderate conferences with a group of providers monthly. During these conferences, providers discuss patient symptoms and treatment history while specialists make recommendations for future treatment planning. This learning environment allows all providers to learn about treatment recommendations for current patients as well as prepare for patient conditions they may come in contact with in the future.

Project ECHO increases the reach of the specialist in a constructive, effective manner. This program is not simply a provider-to-specialist consultation that only affects the care of one patient. This program has the potential to affect the care for all patients being treated by the PCPs participating in the conferences.

To promote expanded access to specialists, an assessment will be completed identifying the current reach of Project ECHO, identifying gaps (e.g., geography or by specialty) and setting goals for program expansion.

Planned Actions (Secondary Drivers and Metrics)

- Conduct an assessment identifying the current reach of Project ECHO. By Q3 2017, an assessment will be completed identifying the current reach of Project ECHO, what percentage of providers have access to additional specialist support, gaps and goals.
- Ensure that PCPs have access to specialists to support treatment decisions. By Q4 2019, the number of PCPs who have access to specialists will be increased from baseline (as determined through the assessment) by 15 percent.

5. Support providers routinely practicing at the highest level of their scope of practice to improve access.

An additional method to increase health care access is to ensure that patients are seen by the right level of service provider based on patient care needs and the provider's scope of practice. To the extent feasible, Nevada will utilize physician extenders. Physician extenders are health care professionals with advanced degrees and medical training to support both patients and providers.[lxxxviii] In this context, physician extenders largely refer to advanced practice registered nurses and physician assistants. Due to their advanced training, physician extenders can complete physical examinations, and diagnose and treat patients for a variety of conditions. Patients not only receive quality care, but some providers have found that physician extenders pursue a more holistic approach.[lxxxix]

Ensuring that providers practice to the highest level of their scope of practice increases efficiency within the health care system. PCPs can focus their time and attention on those patients with more complex needs.

To support this effort, Nevada will develop education to make the public aware of opportunities and efficacy of physician extenders. In that process, Nevada will review reimbursement policies to determine if there are any gaps and set goals for the increased statewide use of licensed staff as physician extenders.

Planned Actions (Secondary Drivers and Metrics)

- Develop training and education to support awareness of existing scope of practice by Q2 2018.
- By Q3 2018, reimbursement policies that support appropriate use of practice levels will be reviewed, gaps identified and goals set.
- Encourage utilization of licensed staff as physician extenders (i.e., midwives, advanced practice nurses, nurse anesthetists, and physician assistants). By Q4 2018, the utilization of physician extenders will have increased from baseline by 20 percent.

6. Promote Health Care Workforce Development.

To mitigate access issues in Nevada, workforce development must be promoted. Additional practicing physicians are needed. The University of Nevada is seeking to expand and increase the number of physicians in the state and Nevada will support the UNSOM and UNLV effort while payers work collaboratively to address workforce issues and improve access.

Nevada will prioritize opportunities to optimize funding available to support graduate medical education (GME) and increase physician access. Additionally, Nevada will review loan forgiveness programs to incentivize physician retention in targeted HPSAs.

Planned Actions (Secondary Drivers and Metrics)

- Identify opportunities to secure state funds sufficient to draw down full GME funds available to the state. By Q3 2018, the state has reviewed opportunities for GME, gaps identified and new goals set.
- Review loan forgiveness for physicians trained and remaining in rural areas for sustained practice period. By Q1 2018, the state has reviewed loan forgiveness programs, identified gaps and set new goals. The number of practicing Nevada physicians in targeted HPSAs increases over baseline.

AIM: Improve Quality Health Outcomes for All Nevadans

Nevada's third aim is to improve quality health outcomes achieved. Public and private health care payers alike maintain goals and programs to improve prevalent and high-cost health care conditions. In order to attain greater statewide success, a more aligned and coordinated effort must be undertaken. Multi-payer efforts must align and support one another. These efforts must not add administrative burden for the provider, resulting in reduced provider satisfaction and acceptance. The use of national quality metrics and methodologies will be utilized to the extent possible. During the establishment of these common metrics, the PHIC and its committees will remain cognizant of the special reporting requirements for IHS under the Government Performance and Results Act (GPRA).

The drivers listed document the actions that Nevada will take to directly impact clinical care treatment programs.

1. Increase education and adoption of evidence-based components of tobacco cessation programs across payers.

Tobacco use in Nevada is reported through the BRFSS to the CDC. This information is also reported in the *DHHS Fact Book* referred to as "Nassir Notes."[xc] In comparing the percent of Nevadans who smoke compared to the United States, Nevada has routinely been above the national average. The only change to this trend occurred when there also was a data collection methodology change. *Figure 21* illustrates tobacco usage in Nevada.

Figure 21: Tobacco Utilization

Adults Who Are Current Smokers	2005	2006	2007	2008	2009	2010	2011	2012	2013*	2014
Nevada %	23%	22%	22%	22%	22%	21%	23%	23%	18%	19%
Nevada Rank	39	36	35	42	41	42	35	34	27	27
U.S. %	21%	20%	20%	19%	18%	17%	21%	21%	20%	19%

The percentage of Nevada adults who are current smokers is the same as the average for the United States as a whole (CDC, Behavioral Risk Factor Surveillance System).
** There was a change in data collection methodology significant enough to constitute a break in the trend.*

Smoking has long-term health impacts that result in costly care and reduced life expectancy. It is one of several modifiable behaviors that can prevent the onset of chronic disease.

To combat this issue, Nevada maintains the Nevada Tobacco Quitline. The Nevada Tobacco Quitline is a free telephone and online coaching service for any Nevada resident who is ready to quit using tobacco. The service is designed to be convenient and confidential for residents who contact the Quitline. Residents are able to receive tobacco cessation information, coaching and access to free Nicotine Replacement Therapy.[xci]

Currently, the Quitline resource is underutilized. On an average month, the Quitline receives fewer than 280 calls, but in some months has reached volumes nearly twice that. This shows that there are residents interested in taking steps to curb this addiction. Although supporting residents who are ready to quit smoking has short-term costs, the long-term savings can be substantial.

The Tobacco Prevention and Cessation Program is managed through the DPBH. Currently, the program does not have sufficient funding for broad marketing campaigns. Marketing occurs but is restricted to media campaigns aimed at limited markets or subpopulations. Making communities aware of such resources and tobacco cessation programs through effective campaigns can alleviate the burden of disease brought on by such behaviors and provide individuals with options when they decide to quit tobacco. The Nevada SHSIP will support increased marketing and awareness of tobacco cessation programs.

Education will not be limited to tobacco products. The increased usage of e-cigarettes has been dramatic and is a growing concern. Regardless of the method of consumption, nicotine has harmful health effects. As a result, Nevada will evaluate the development of education awareness materials related to the risks involved with e-cigarettes.

Additionally, with MPC payers, Nevada will explore actions across payers that can be taken to increase access to tobacco cessation services through limiting administrative barriers. An example of an administrative change may be through reduced prior authorization requirements.

Planned Actions (Secondary Drivers)

- Support marketing of Quitline and awareness of public health tobacco cessation programs
- Promote educational awareness of the risks involved with e-cigarettes
- Partner with other payers to explore limiting administrative barriers (e.g., prior authorizations) related to accessing nicotine replacement products and tobacco cessation services

2. Promote a statewide, integrated behavioral health care system with youth and adult focus on prevention and early intervention as well as persons with Serious and Persistent Mental Illness (SPMI).

The National Institute of Mental Health (NIMH) reports that in 2013, an estimated 18.5 percent of all adults in the United States, or 43.8 million adults aged 18 or older, had a mental illness in the past year.[xcii] Of those, 4.2 percent, or 10 million adults, were diagnosed with a mental, behavioral or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to be considered a serious mental illness that resulted in serious functional impairment, substantially interfering or limiting patient activities.[xciii] Total estimated costs associated are in excess of $300 billion per year for SPMI.[xciv]

The impact of serious behavior health issues is being addressed through several different efforts.

- ***SAMHSA*:** Nevada is partnering with the federal government on various initiatives. Specifically, SAMHSA is charged with reducing the impact of substance abuse and mental illness on America's communities. SAMHSA offers support through education and funding grant initiatives. Current initiatives underway in Nevada include:
  - *Block Grants for Community Mental Health Services:* This grant provides funding and technical assistance to provide comprehensive, community based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community based mental health system.
  - *Substance Abuse Prevention and Treatment Block Grant:* This grant supports state planning, implementation and evaluation activities to prevent and treat substance abuse and promote public health.

    These two mandated block grants require an annual application to receive predefined federal funding allocations. These dollars are needed to care for these persons. However, these public health initiatives could be promoted and championed by all payers of health care to more effectively reinforce the program strategies and activities.
  - *Nevada Safe Schools / Healthy Students:* In 2013, the Nevada DHHS' DPBH was one of only seven states to receive this grant. The award amount of $8,677,011 is a four-year program to fund pilot studies that will develop and evaluate the effectiveness of school programs designed to

improve behavioral health.[xcv] The pilot studies will be carried out by the Children's Cabinet of Northern Nevada on behalf of the Washoe County School District; the Healthy Communities Coalition on behalf of the Lyon County School District; and the Nye Community Coalition on behalf of the Nye County School District.

The goals of the grant are to:

- Increase the number of children and youth who have access to behavioral health services in the pilot regions
- Decrease the number of students who abuse substances
- Increase supports for early childhood development
- Improve school climates
- Reduce the number of students who are exposed to violence

❖ *Projects for Assistance in Transition from Homelessness (PATH):* This program assists homeless individuals, or those at risk of becoming homeless, to access mental health services, apply for housing assistance, and/or maintain current housing. Providers throughout the state are contracted to meet these program objectives.

A key means to supporting these programs statewide is through sharing information about their successes, challenges and lessons learned in order to spread and increase their effectiveness. Nevada will support the current SAMHSA initiatives by ensuring broader dissemination and stakeholder engagement.

◆ ***Certified Community Behavioral Health Clinics***: A new initiative recently awarded in Nevada is a planning grant for CCBHCs. The grant requires Nevada to certify community behavioral health clinics. CCBHCs are responsible for care coordination, which involves organizing care activities among different services and providers, and across various facilities. Care coordination is considered an activity and not a service that is submitted on a claim. The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as "deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate and effective care to the patient."[xcvi]

Facilities could include FQHCs and RHCs, inpatient psychiatric facilities, hospital outpatient clinics, substance use detoxification services, post detoxification step down services and residential programs. Coordinated care also extends to such entities as schools, child welfare agencies, juvenile and criminal justice agencies and facilities, IHS youth regional treatment centers, state-licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

Goals for this program include improving the availability of, access to and participation in assisted outpatient mental health treatment, and demonstrating the potential to expand available behavioral health services without increasing net federal spending. The SHSIP will support efforts to ensure these goals are met.

- ***Suicide Prevention*:** The Nevada Office of Suicide Prevention (NOSP) is responsible for the development, implementation and evaluation of the NSPP to be updated for state fiscal year (FY) 2015.[xcvii]

  A major initiative by the team is based on the Veterans' Suicide Mortality Report and working with the Veterans Services Green Zone Initiative to prevent suicide among service members, veterans and families. In February 2012, the Nevada DPBH, formerly the State Health Division, released a report on suicide mortality in Nevada's military veterans. The report found that the suicide fatality rate was surprisingly high, 46 deaths per 100,000 Nevada veterans, compared with the rate of 19 deaths per 100,000 population for Nevada. Furthermore, Nevada's veteran suicide rate was 74 percent higher than the national rate of 12 deaths per 100,000 population. The Health Division's 2012 report was a "call to action," to address the epidemic of veteran suicide in Nevada. Since February 2012, multiple initiatives have been undertaken to combat veteran suicide.[xcviii]

  NOSP is coordinating numerous suicide prevention efforts across the state for the safety of all residents with strong partnership from local coalitions, school districts and the NOSP. NOSP staffs Nevada's first Committee to Review Suicide Fatalities. NOSP also is increasing awareness about addressing access to lethal means through the programs such as Suicide-Proof Your Home, Securing Firearms Education and The 11 Commandments of Gun Safety. NOSP is partnering with Project Aware to provide statewide Youth Mental Health First Aid training to communities through NOSP and Project Aware.

  The SHSIP will serve as a means to focus these crucial prevention and early identification efforts that are forming an integrated behavioral health system.

Planned Actions (Secondary Drivers)

- Support current SAMHSA initiatives in Nevada
- Support CCBHC grant initiatives to increase integration of physical health and behavioral health treatment
- Support the use of technology by certified peer specialists for behavioral health treatment regimens for veterans and additional at-risk groups

3. Promote increased healthy lifestyle practices and availability of obesity prevention programs for youth and adults.

According to the Nassir report, although Nevada's obese population (those with a Body Mass Index [BMI] of 30 or higher) is under the national average, more than a quarter of the population was considered obese in 2013. *Figure 22* shows Nevada's obesity rates compared with the national average.

Figure 22: Obesity Rates

Obesity		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Nevada	%	21%	21%	25%	25%	26%	26%	23%	23%	26%	26%
	Rank	**11**	**8**	**24**	**13**	**19**	**21**	**5**	**4**	**17**	**11**
United States	%	23%	24%	25%	26%	27%	27%	27%	28%	28%	29%

Nevada Department of Health and Human Services. March 2015. Accessed December 2, 2015.
http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/NassirNotes.pdf

Being overweight poses serious health risks, including high cholesterol, high blood pressure, heart disease and type 2 diabetes. Modifiable health behaviors that are pivotal in chronic disease prevention and successful treatment include physical activity and nutrition. Proper nutrition and physical activity must be stressed at an early age, since youth-focused programs offer the greatest opportunity for long-term change. To sustain the associated behavioral changes, a family-focused plan with support by parents and caretakers is needed. Nevada will support and align programs that seek to address this issue.

Healthy Hearts Program: The Children's Heart Center of Nevada began the Healthy Hearts Program in 2002, which is a comprehensive, family-based, pediatric 12-week weight management program for families with overweight children. The goal of the program is to promote healthy lifestyles for the entire family with an emphasis on modifying behaviors, improving eating habits, increasing physical activity and improving self-esteem, which aligns with the goals of Nevada.[xcix] The PHIC will identify methods to support and make the public aware of this program.

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Grant*:* The MIPCD grant was authorized through Section 4108 of the ACA for purposes of incentivizing Medicaid beneficiaries to participate in prevention programs and demonstrate changes in health risk and outcomes. CMS supported this grant based on significant research evidence that confirmed financial incentives impact consumer engagement in modifying behaviors.

Nevada was one of 10 states awarded a grant in 2011 to implement an incentive program to support consumer engagement. The program was required to be comprehensive, evidence-based, widely available and easily accessible. Nevada was awarded $3,565,311 for the grant period that ended on December 15, 2015.[c]

Nevada identified three separate components to encourage participation by Medicaid and Nevada Check Up beneficiaries. Individuals receive points, redeemable for rewards, for participating in programs to control weight, lower cholesterol and lower blood pressure to avoid the onset of diabetes.

- Incentives were offered to beneficiaries at risk of, or diagnosed with, diabetes who agreed to participate in diabetes self-management programs conducted by Nevada's MCOs, Amerigroup and United HealthCare/Health Plan of Nevada.
- Incentives also were offered to a targeted subpopulation of children at risk for heart disease. According to the MIPCD program design, support and facilitation for

behavioral change and risk reduction were provided through a multidisciplinary evidence-based program conducted by Children's Heart Center.

The Grants Management Unit within the DHHS oversaw grant operations and evaluation. As a part of the grant, MIPCD participants were able to access a member portal to view and redeem incentives. The lessons learned through this grant regarding both diabetes management and incentives will be used to inform Nevada in improving patient engagement and chronic care management.

Strategic planning to manage obesity through prevention has been a long-term objective for Nevada. In 2005, the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease (CWCD) was created to increase public awareness related to physical fitness and wellness activities, including the prevention of obesity, chronic diseases and other diseases. This council is part of the Nevada DPBH that helps steer state objectives. Currently, Nevada receives federal funds from the CDC under the Obesity Prevention and Control grant.

Alignment of these initiatives with all payers will most effectively develop common goals and support models for increased healthy lifestyle practices and reduced obesity prevalence.

Planned Actions (Secondary Drivers)

- Support Children's Heart Center's pediatric obesity program
- Continue components of the expired Medicaid Incentives for Prevention of Chronic Diseases Grant
- Support current DPBH obesity prevention grant

4. Increase implementation of best practices for diabetes management programs with an emphasis on prevention in the youth population.

The percent of adult Nevadans who report being told by a doctor that they have diabetes was 10 percent in 2014 and has been tracking upward over the course of the last 10 years. *Figure 23* illustrates Nevada's diabetes ranking as compared with the national average.

Figure 23: Diabetes Ranking

Diabetes		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nevada	%	**6%**	**7%**	**8%**	**8%**	**9%**	**8%**	**9%**	**10%**	**9%**	**10%**
	Rank	**15**	**21**	**26**	**25**	**30**	**16**	**22**	**37**	**15**	**22**
United States	%	7%	7%	8%	8%	8%	8%	9%	9%	10%	10%

Nevada Department of Health and Human Services. March 2015. Accessed December 2, 2015.
http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/NassirNotes.pdf

The percent of Nevadans with high blood pressure has also been increasing, while those with high cholesterol have been steady at above one-third of all Nevadans. See *Figures 24* and *25* for Nevada's ranking in high blood pressure and cholesterol, respectively.

Figure 24: Hypertension Ranking

High Blood Pressure		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Nevada	%	24%	24%	24%	24%	27%	27%	28%	28%	31%	31%
	Rank	**16**	**16**	**15**	**15**	**24**	**24**	**17**	**17**	**24**	**24**
United States	%	25%	25%	26%	26%	28%	28%	29%	29%	31%	31%

Nevada Department of Health and Human Services. March 2015. Accessed December 2, 2015. http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/NassirNotes.pdf

Figure 25: Elevated Cholesterol Ranking

High Cholesterol		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nevada	%	37%	39%	39%	37%	37%	39%	39%	37%	37%	38%
	Rank	**48**	**48**	**48**	**19**	**19**	**30**	**30**	**18**	**18**	**27**
United States	%	33%	36%	36%	38%	38%	38%	38%	38%	38%	38%

Nevada Department of Health and Human Services. March 2015. Accessed December 2, 2015. http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/NassirNotes.pdf

To combat this issue, Nevada will identify ways to support current payers' existing diabetes programs, particularly those focused on youth prevention. As mentioned, obesity and diabetes prevention are inter-related issues. The MIPCD worked to address them together. The MCOs both have programs in place to address diabetes, as does PEBP and the state's care management organization (CMO). These programs need to be discussed by all payers to find similar methods, best practices and engagement incentives that will support all Nevadans regardless of insurer. Programs like the Children's Heart Center that support physical activity to reduce diabetes in youth and encourage long-term commitments and habits are crucial to Nevada's objectives. Identification of those youth at risk of developing diabetes and linking them to programs is vital.

The public health department's Diabetes Prevention and Control Program (DPCP), funded by the CDC, is a program already in place that requires wider awareness and support. The goal of the program is to reduce disease, disability and death related to prediabetes and diabetes. Activities that the grant supports include developing integrated approaches to reduce the diabetes burden in Nevada. These approaches will not only address legislative policy, but professional and public education throughout the state via Diabetes Prevention Education and Diabetes Self-Management Education Programs. Linking community partners in these initiatives is a prominent objective.[ci] The DPCP is working with the Nevada Statewide Coalition Partnership and the Quality and Technical Assistance Center (QTAC) for Diabetes Education training primary care office health care staff on screening and referral steps. The program also is seeking to increase awareness through the Nevada Wellness website: (http://nevadawellness.org/community-wellness/diabetes-education), which not only offers diabetes management information, but offers the public wide-ranging information on Nevada's Healthy 2020 goals and methods to improve individual, workplace, school and community wellness.

The CDC reports that for every 100 high-risk adults (age 50) participating for three years in the National Diabetes Prevention Program (DPP), 15 new cases of Type 2 diabetes were averted, along with $91,400 in health care costs.[cii] Therefore, it is clear that assembling a broad array of stakeholders, payers and providers to address diabetes in a more coordinated fashion will have a greater impact for all Nevadans.

Planned Actions (Secondary Drivers)

- Support current payers' diabetes programs, including PEBP, MCOs and CMO
- Explore and support actions to increase the early identification of individuals with diabetes and those individuals at increased risk for diabetes, with emphasis on the youth population
- Support current DPBH diabetes and prevention initiative through early intervention and focused on quality outcomes

5. Increase evidence-based prevention and transitions of care management for patients with cardiovascular disease.

Heart disease is the leading cause of death in the United States and Nevada. *Figures 26* and *27* illustrate Nevadans' ranking in heart disease and heart attacks, respectively.

Figure 26: Heart Disease Ranking

Cardiac Heart Disease		2006	2007	2008	2009	2010	2011	2012	2013	2014
Nevada	%	4%	5%	4%	4%	4%	4%	4%	4%	3%
	Rank	**17**	**38**	**28**	**22**	**25**	**19**	**24**	**24**	**10**
United States	%	4%	5%	4%	4%	4%	4%	4%	4%	4%

Nevada Department of Health and Human Services. March 2015. Accessed December 2, 2015.
http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/NassirNotes.pdf

Figure 27: Heart Attack Ranking

Heart Attack		2006	2007	2008	2009	2010	2011	2012	2013	2014
Nevada	%	5%	5%	4%	4%	5%	5%	5%	5%	4%
	Rank	**39**	**37**	**25**	**31**	**42**	**38**	**38**	**28**	**26**
United States	%	4%	4%	4%	4%	4%	4%	4%	4%	4%

Nevada Department of Health and Human Services. March 2015. Accessed December 2, 2015.
http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/NassirNotes.pdf

Heart disease is impacting mortality and morbidity, as well as driving up health care costs. Heart disease and stroke account for more than $312.6 billion in expenditures and lost productivity annually.[ciii] There has been little improvement to this issue over the last decade, but Nevada will seek to support new focused initiatives. To this end, a Heart Disease and Stroke Plan has been developed for the state of Nevada. This report reminds the public that approximately one out of every three deaths in the U.S. is caused by heart disease or stroke. Approximately 700,000 U.S. citizens experience a stroke and 150,000 deaths are

caused by stroke. The plan outlined strengths, weaknesses, opportunities and threats to improving rates of heart disease and stroke to develop a clear, cohesive plan.

Million Hearts Program: This plan highlighted the national Million Hearts initiative.civ This initiative seeks to prevent 1 million heart attacks and strokes by 2017. Five principle objectives are supported by this program:

- Improving access to effective care
- Improving the quality of care for the ABCS of heart disease (preventive steps)
- Focusing clinical attention on the prevention of heart attack and stroke
- Activating the public to lead a heart-healthy lifestyle
- Improving the prescription and adherence to appropriate medications for the ABCS (see below)

This initiative has been adopted by Nevada and incorporated in the Heart Disease and Stroke Plan. The initiative informs individuals on the ABCS basics to prevention:

A – Take aspirin as directed by your health care professional

B – Control your blood pressure

C – Manage your cholesterol

S – Don't smoke

This simplified, unified national messaging will assist all individuals in understanding the critical means toward prevention supported across the country. Because this is a national initiative, Nevada will encourage all Nevada payers to join in this evidence-based approach.

Transitions of Care: If an individual experiences a heart- or stroke-related event, patients are at-risk for readmission for adverse events post-discharge. Supporting patients during transitions from inpatient to outpatient care is essential. A study referenced by AHRQ's Patient Safety Network found that nearly 20 percent of patients experience adverse events within three weeks of discharge and nearly three-quarters of those adverse events could have been prevented or ameliorated.cv Due to the already high costs of heart-related admissions, ensuring quality transitions of care can reduce further health care expenditures. Utilization of community paramedicine and CHWs specifically for this population therefore has been identified as a goal for Nevada. As described throughout this plan, these health care providers offer vital support, training and referrals to patients so that they can more effectively follow discharge plans, access providers and seek social service support when necessary, thus avoiding readmissions and regaining the ability for self-care in the home.

Planned Actions (Secondary Drivers)

- Support Million Hearts initiative
- Support use of community paramedicine and CHW programs during transitions from inpatient to outpatient care for cardiac patients

6. Increase quality outcomes through focused efforts on early prevention programs for youth and adults.

Focusing on the habits of children to support a healthy lifestyle for all Nevadans begins early. In fact, ensuring proper prenatal care decreases the risk of a complicated delivery. Complex deliveries that result in babies in the Neonatal Intensive Care Unit (NICU) can average more than $3,000 a day.[cvi] Reduced adverse deliveries and supporting prenatal care initiatives through public health will increase a child's chances to live a long, healthy life.

If, however, a baby is born with complications, follow-up care for the mother and child can be supported through the use of CHWs. During this fragile period, if a mother requires social supports that are not accessible, the health of the newborn can be negatively impacted. Allowing CHWs to connect with and support mother and child post-discharge can offer lasting benefits.

As the infant grows, the CHW can ensure that the family is connected to a PCMH, which will continue to support the family. Well-child visits throughout the first year and into adolescence allow the PCP to complete essential screenings and share health information so that a well-developed relationship is established that continues into adulthood.

Planned Actions (Secondary Drivers)

- Support improvement of prenatal care through the current public health initiative
- Support improvement of prenatal care through use of CHWs to support new mothers in follow-up care
- Support increase in well-child visits through PCMH and HIT infrastructure
- Support increase in immunizations through PCMH and HIT infrastructure
- Support increase of utilization of pharmacies to improve medication management
- Support awareness of sexually transmitted diseases (STDs) prevention

7. Support and align hospitalization admission, readmission and ED utilization reduction initiatives.

In 2013, the cost of hospital spending grew to $936.9 billion annually within the United States. These dollars represent over 35 million discharges nationwide, with an average length of stay of 4.8 days.[cvii] Additionally, due to the frequent rate of readmissions, particularly for the Medicare population (18 percent occurrence), readmission costs are significant, specifically $15 billion for Medicare alone.[cviii] For just four high-volume conditions, approximately 500,000 readmissions accounted for $7 billion in 2013.[cix]

The next highest cost of service was for physician and clinic services, which rose to $586.7 billion annually. ED visits totaled more than 136 million visits.[cx,cxi] Of this care, patient expenses also have been on the rise. Out-of-pocket expenses accounted for $339.4 billion in 2013.[cxii]

According to all-payer data collected by CHIA for Nevada, in the first two quarters of 2015 alone, billed inpatient charges were more than $10 billion. ED utilization in 2012 was near a million visits. *Figures 28 and 29* show inpatient utilization and ED utilization for Nevadans, respectively.

Figure 28: Inpatient Utilization

Nevada (Q1-Q2 2015 data)	Inpatient Billed Charges	Inpatient Utilization
Clark County	$8,589,928,827	190,024
Rural County	$111,449,534	12,095
Washoe/Carson City County	$1,544,091,044	57,343
Total State	$10,245,469,405	259,462

Center for Health Information Analysis for Nevada, Nevada Healthcare Quarterly Reports (NHQR), 1st to 2nd Quarter 2015, September 28, 2015.

Figure 29: ED Utilization

Nevada (2012 data)	ED Utilization
Clark County	632,984
Rural County	105,489
Washoe/Carson City County	203,849
Total State	942,322

Center for Health Information Analysis for Nevada. Nevada Healthcare Quarterly Reports (NHQR). Calendar year 2010. Produced August 28, 2012.

Preventive actions including improved population health management and chronic disease management to avoid hospitalization and ED utilization in the first instance have been discussed in Nevada's goals. AHRQ additionally warns that 40 percent of patients are discharged with pending test results or a plan to complete diagnostic testing that, if not completed, places patients at risk.

The consequences of growing admissions, readmissions and ED usage impact national, state and personal budgets throughout the country and hold real risk for the patient. Effective, safe care for patients who are admitted, along with supported outpatient care, is imperative. For these reasons, Nevada has included planned actions specific to hospital admission, readmission and ED utilization reduction.

Steps have already been taken by payers to implement patient-focused, coordinated, evidenced-based, data-informed programs to address quality and costs related to hospital services. Medicare implemented the Hospital Readmissions Reduction Program targeting improved care for heart failure, acute myocardial infarction and pneumonia in order to reduce the rate of 30-day readmissions.

In fact, the ACA requires CMS to reduce payments to designated hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. To avoid penalties, hospitals have identified improvements that show real change to the rate of readmission.

Focusing on medication reconciliation, ensuring patients complete appointments post-discharge and brief patient assessment and communications can decrease readmissions.

Community Paramedics and CHWs for At-Risk Patients: The use of community paramedics and CHWs to monitor discharge treatment and medication needs, and patient care access to post-discharge appointments can reliably improve outcomes for Nevadans as well.

2-1-1 and Nurse Call Centers: Supporting patients through telephonic access to information and social service needs can reduce over-utilization of the ED. Nevada currently operates Nevada 2-1-1, which is a free service that provides information about vital health and human service programs that are available throughout the state. Nurse call centers are offered by some payers and provide access to nurses 24 hours a day. These call centers offer patients an opportunity to speak directly to nurses about their current symptoms and receive recommendations on follow-up treatment either to the ED, urgent care or to follow-up with the patient's PCP. Allowing Nevadans to speak directly with professionals to triage their need to encounter the health care system can assist in avoiding unnecessary ED costs. This can be particularly important immediately post-discharge to avoid complications resulting in readmissions.

Telemedicine/Telehealth: During follow-up care, other technology solutions are available. As has been described, opportunities to use technology to support patients who reside in rural settings can be critical post-discharge. The use of telemedicine/telehealth services can dramatically improve outcomes for patients post-discharge, avoiding both readmissions and ED visits. Using these tools as effectively and broadly as possible to support patients will be important in efforts to reduce hospital utilization and keep patients in the community.

Asthma Control: Asthma results in 1.8 million ED visits and 439,000 discharges annually across the country.[cxiii] However, environmental factors (e.g., dry weather, dust, etc.) place Nevada above the rest of the country in rates of asthma and ED utilization has been on the rise.[cxiv] Identifying methods to manage asthma patients effectively to reduce unnecessary hospital services will be included in the development of Nevada's strategy to reduce hospital utilization.

Planned Actions (Secondary Drivers)

- Support usage of community paramedics and CHWs for follow-up care for at-risk patients
- Support increased usage of Nevada 2-1-1 and potential coordination of nurse help lines
- Support increased use of telemedicine to reduce hospital admissions, readmissions and ED utilization
- Support asthma control methods

8. Support improved patient experience.

A final method that Nevada will employ to improve access will be through supporting improved patient experiences. Compassionate, patient-centered care versus care that does not consider the needs or goals of the patient can impact overall health care engagement and success. Providers who take the time to understand, develop shared-decisions and communicate with patients empower and engage them to more fully self-manage and take responsibility of their care. Because patient experience impacts health outcomes, monitoring standardized surveys are the primary tool to capture and track this dimension of the care experience.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) and other tools available offer important insight to physicians and payers regarding meeting the needs of patients. Nevada will support increasing the use and completion of surveys, potentially through patient incentives, and will utilize the resulting information to assessment improvements in access to care.

Planned Actions (Secondary Drivers)

- Support increased use of CAHPS Hospital, Clinician and Group Surveys and Health Plan surveys to measure quality in key areas related to population health improvement
- Explore options to encourage increased response rates for health surveys

AIM: Foster Greater HIT and Data Infrastructure.

Nevada recognizes the importance of developing a strong HIT infrastructure and greater availability and use of electronic health information at the point of care. Opportunities to improve the availability, use and completeness of electronic health information will be implemented through the SHSIP. Systems, infrastructure and technical assistance to support these improvements will be developed and deployed. Patients, providers, the public and state staff also will utilize this enhanced HIT environment as described below.

1. Promote statewide HIE.

Value-based payments will incentivize providers to improve care coordination to better manage patient care. Value-based payments also promote broader thinking by providers regarding the more expansive and often long-term impacts of care decisions on both costs and outcomes. To make informed decisions under a VBP model, providers must be supported by connectivity to a robust and rich statewide HIE. In addition, value-based payment arrangements will require submission of clinical quality measures from the providers. Certain data elements do not reside within claims data (e.g., blood pressure measures, blood glucose control, etc.) but will exist within the clinical data that can be extracted from EHR data and sent via HIE. Claims and HIE information need to be linked when providing patient care, developing care plans, measuring value and quality, and reporting on population health.

Planned Actions (Secondary Drivers)

- Convene an HIE Collaborative to develop a plan to expand HIE connectivity
- Increase direct messaging and notification systems to improve capacity for providers to exchange treatment information
- Develop a provider portal with single sign-on capabilities

2. Develop population health management and analytics tool.

After creating and linking an APCDR with the statewide HIE and state registries, Nevada will procure or create a population health analytics tool that "sits on top" of the APCDR, HIE and state registry data sources. Data residing within registries maintained by the state, such as immunization, cancer, vital records and other registries, will be available and utilized in measuring and reporting population health of Nevadans, as well as other public population datasets. The population health analytics tool will permit the measurement tracking and reporting of population health metrics, publishing population health metrics and driving improvement at the provider, payer and population levels. This robust tool will have the ability to perform detailed sub-analysis to identify trends, improvement, opportunities and disparities.

Using the population health analytics tool, a public-facing dashboard and reporting portal will be developed to increase public transparency regarding population health status and the results of population health improvement efforts. This portal is planned to evolve over time into a transparency website that includes provider-level quality and outcome metrics. This provider-level transparency website will be leveraged to improve patient engagement when selecting providers and seeking high quality health care services.

Planned Actions (Secondary Drivers)

- Procure and implement a population health tool to measure, track and publish population health metrics utilizing data elements from the statewide HIE, DPBH registries and the APCDR

3. Increase provider HIT technical assistance.

Nevada also will provide technical assistance to educate providers on the use of HIT and the HIE, and help providers adopt, implement and become meaningful users of EHRs, while utilizing the HIE to support value-based payment adoption.

Planned Actions (Secondary Drivers)

- Incorporate a HIT toolkit for providers that will educate and promote the adoption, implementation and MU of EHRs, which complements the early work of the REC including work flows

4. Utilize HIT to increase patient engagement, health literacy and joint decision-making.

Using the foundation of the APCDR, HIE and a state registry, a patient portal is planned. The portal will include a portable patient health record, prevention and wellness education,

and patient engagement and empowerment tools. The portal is envisioned to be customized to push or promote information that is most relevant to the individual given his or her medical diagnoses and utilization history. For example, patients with obesity and diabetes in their history would have a customized landing page with topics related to diet, exercise, blood pressure control, foot and eye exams, meaning and importance of hemoglobin A1c measures, and other diabetes management topics.

Planned Actions (Secondary Drivers)

- Develop a centralized public portal with provider-level quality metrics so that individuals can make informed treatment decisions
- Develop a centralized public portal providing health information guidance to Nevadans

5. Develop an All-Payer Claims Data Repository.

Aggregated claims and administrative data from Nevada public and private payers are needed to develop systems to report population health status and improvement, identify statewide gaps and disparities, promote health care transparency initiatives, and provide actionable information. The APCDR must include financial data for analysis and studies of total cost of care to assess the achievement of "smarter spending" along with improved health and outcomes. The authority required to mandate that all payers contribute complete and accurate claims and payment data to the APCDR, as well as the ramifications of not doing so, will need to be discussed by state officials and is expected to require legislative action.

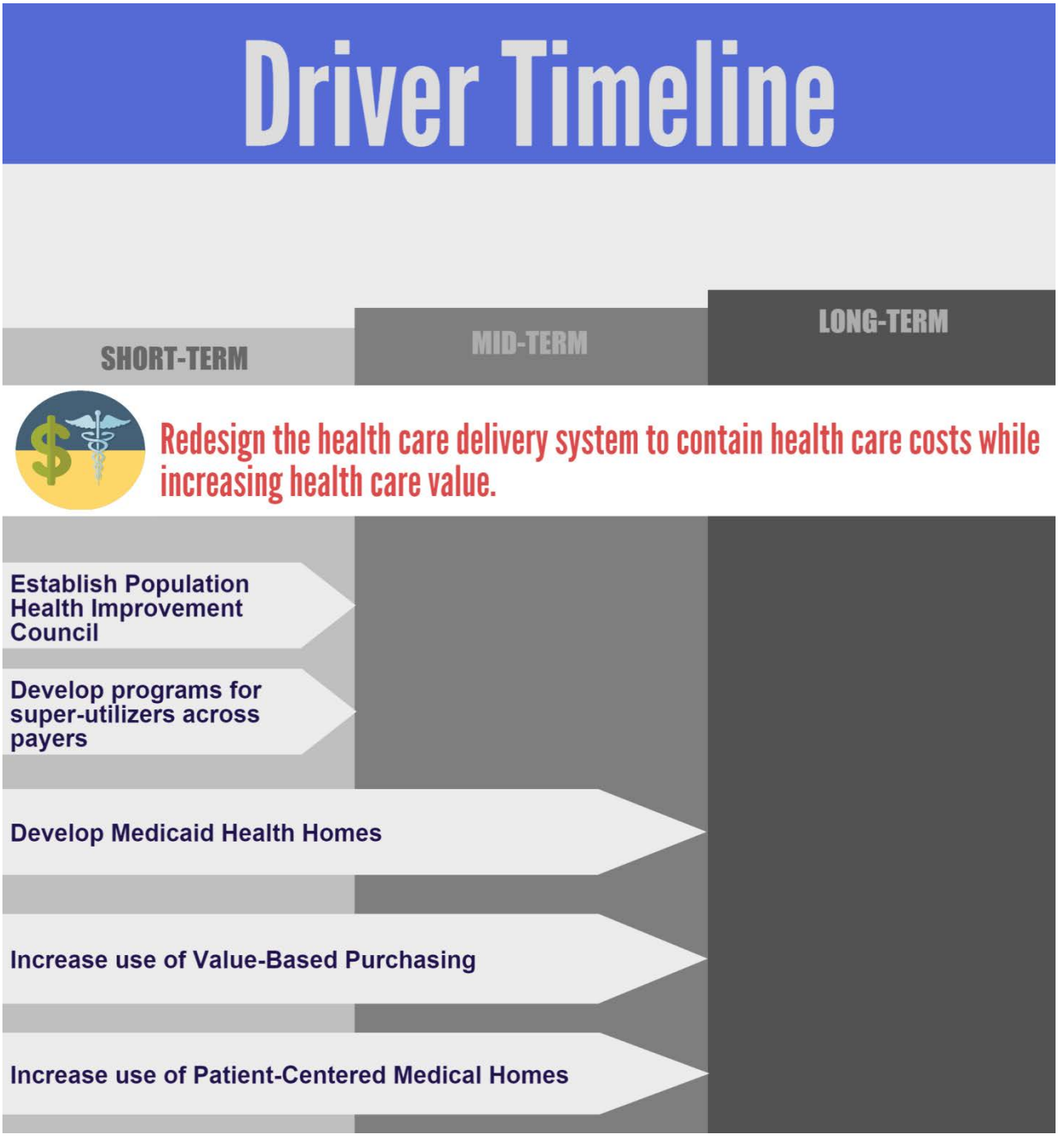
Planned Actions (Secondary Drivers)

- Establish a repository of claims from all payers to assist in measuring population health and health care-related activity

B. Driver Diagram Timeline

The scope and extent of the activities to be performed under the Nevada SHSIP are large and wide sweeping. Implementation of these activities requires prioritization and a realistic view of what is achievable in the short-term (under two years), mid-term (between two and five years) and long term (five or more years). While many of these activities require planning that starts immediately, full implementation or completion of these activities may not be complete for several years. Figure 30 depicts the timeline envisioned for the activities in the driver diagram.

Figure 30: Driver Diagram Timeline



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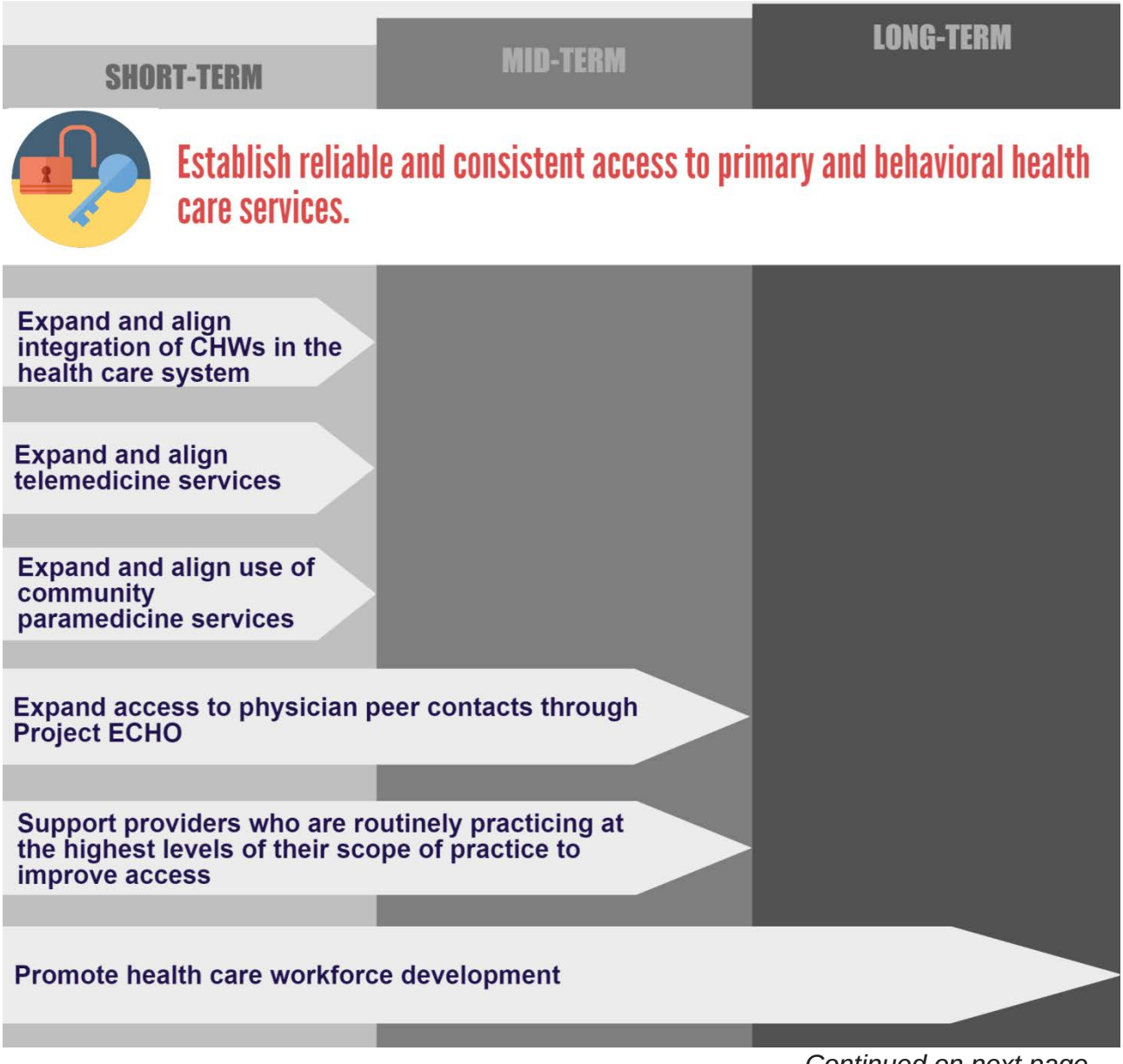

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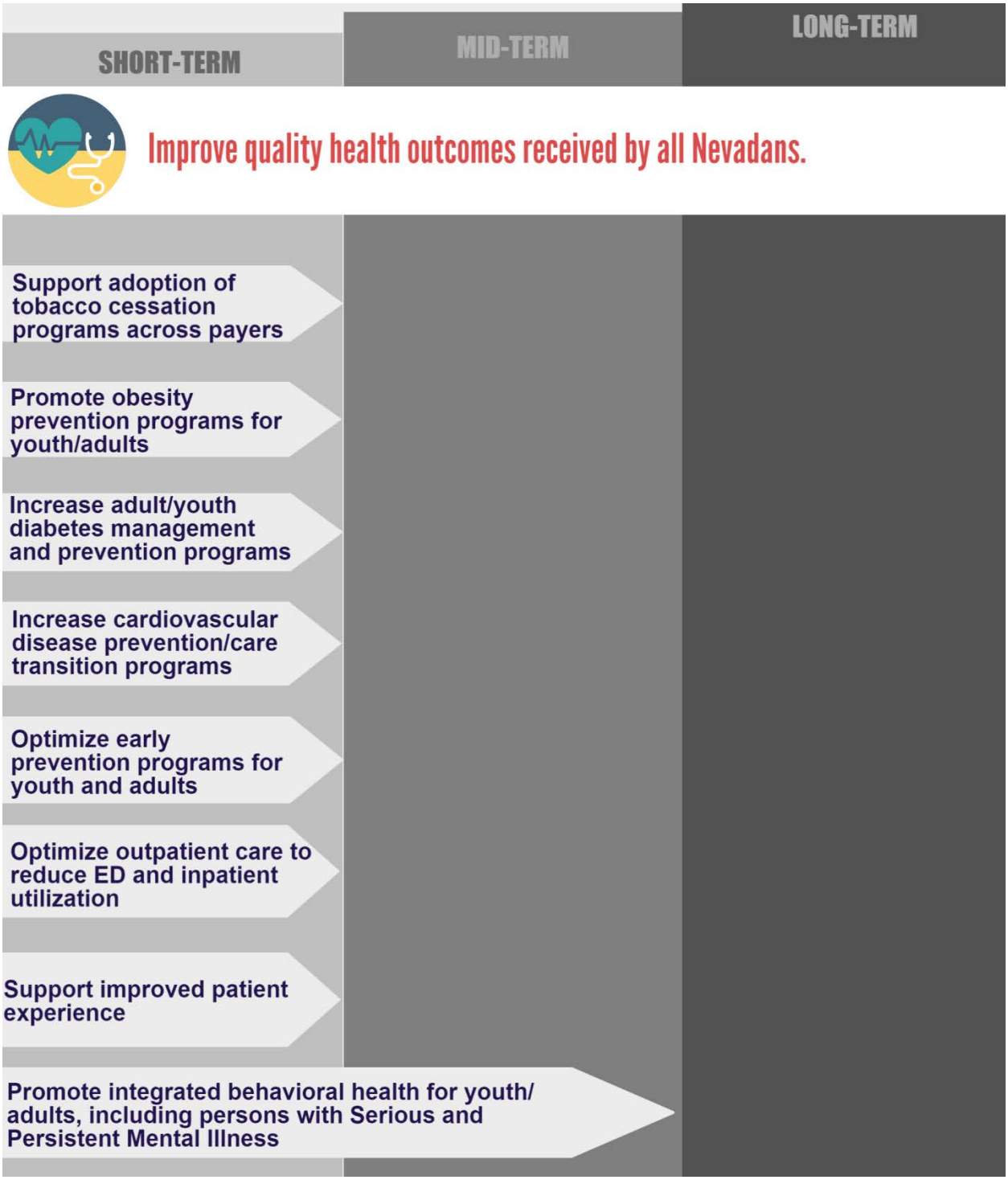

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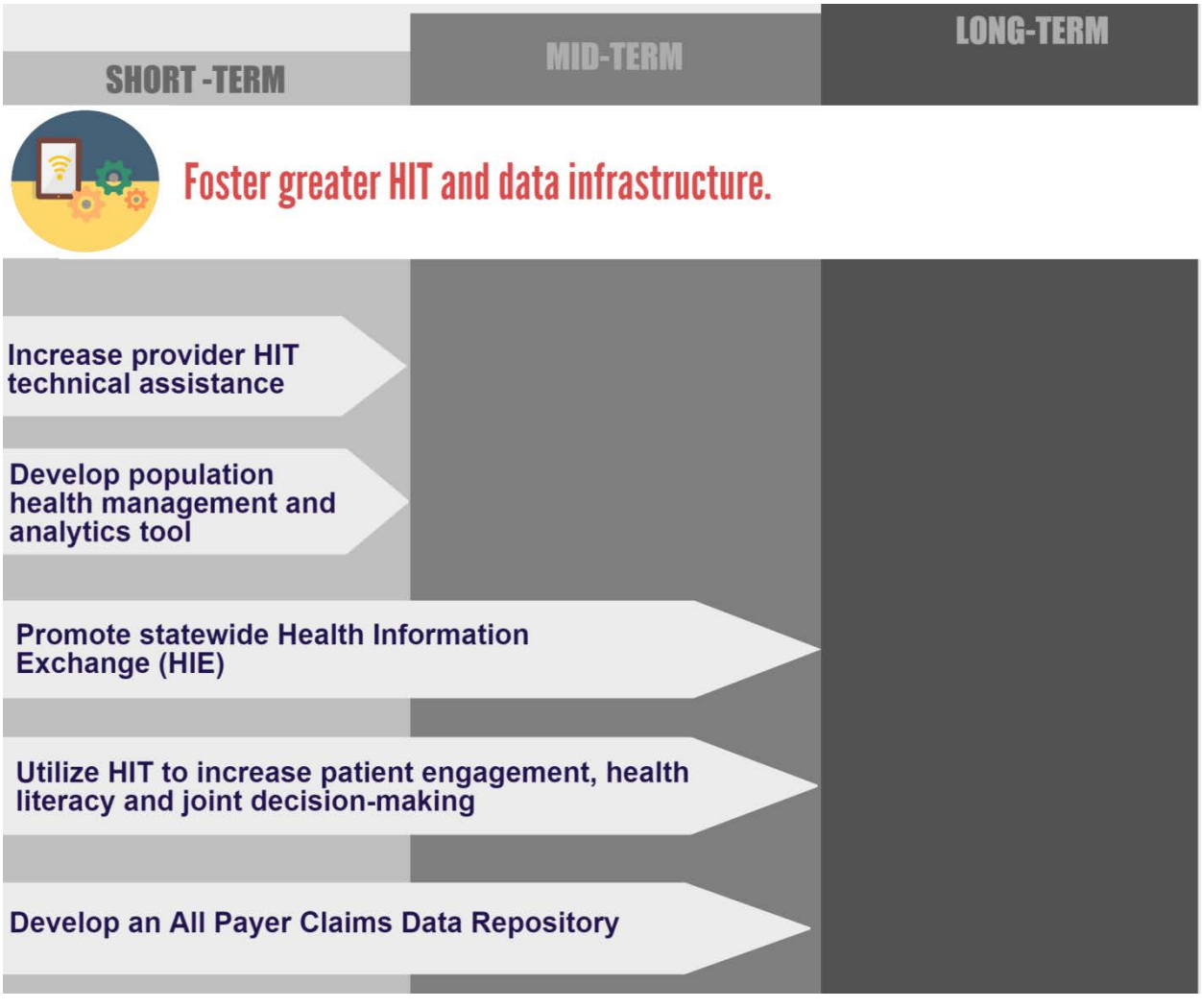

SHORT -TERM
MID-TERM
LONG-TERM
Foster greater HIT and data infrastructure.
Increase provider HIT technical assistance
Develop population health management and analytics tool
Promote statewide Health Information Exchange (HIE)
Utilize HIT to increase patient engagement, health literacy and joint decision-making
Develop an All Payer Claims Data Repository

VII. PAYMENT TRANSFORMATION

Nevada providers have exhibited interest in linking provider payments with quality and outcomes attained. Through comments from Bill Welch, President and CEO of the Nevada Hospital Association, DHCFP learned of the Nevada hospital industry's discussions with the nursing home association regarding strategies, roles and opportunities for collaboration in a bundled payment environment for joint replacement episodes of care. Likewise, DHCFP has received a proposal from the Nevada Health Care Association's (NVHCA) President and CEO Daniel Mathis, outlining a VBP methodology for the nursing home industry. NVHCA's two-pronged proposal seeks to recognize improvements in quality and outcomes for Nevada Medicaid beneficiaries who are residing in a nursing facility while reducing the number of admissions to skilled nursing facilities that become long-term facility residents.

Nevada's payment transformation effort will focus on a progressive migration from volume-based payments to value-based payments. In today's environment, providers are paid based upon the volume of services provided. This FFS payment methodology has the potential to incentivize a number of undesirable behaviors. For example, providers wishing to increase payment revenue may opt to provide additional health care services that may or may not be necessary. Likewise, the current system does not reward quality and superior health outcomes.

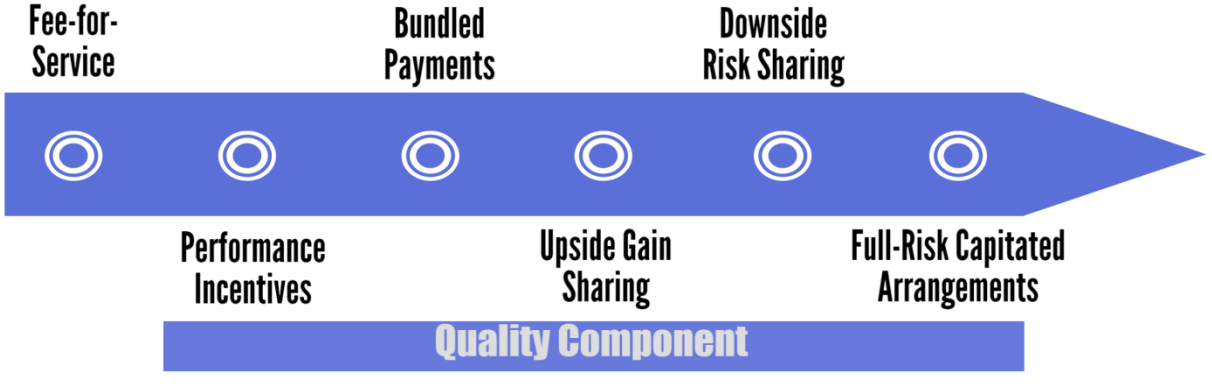
The Nevada stakeholder engagement process revealed the need for a successful transition to value-based reimbursement:

- ***Buy-In:*** While there is high-level agreement among most providers that value-based reimbursement is the appropriate route to take, there is a fair amount of provider reluctance and mistrust with payer implementation strategies. An open and ongoing dialogue must be initiated to promote successful implementation. Communication and support for health care providers during this transition will be critical to ensure understanding and acceptance of such a significant shift in doing business. The alignment of methods across payers also will decrease provider resistance due to shared expectations versus goals at cross-purposes.
- ***Information Availability:*** Providers need more complete and timely data regarding PHI at the point of care. Treatment plans are often constructed with incomplete information, which may lead to duplication of services, missed or delayed diagnoses, inefficiencies, patient safety issues and therapeutic misadventures, all of which may lead to an increase in costs. The HIT strategy described in this plan supports increasing the availability of health information to providers and patients, which will set up the VBP implementation for success.
- ***Understanding of Provider Costs****:* Providers must understand their internal costs to deliver care and to identify where the greatest value can be derived. Also, providers must improve their operational efficiency and consider the use of other resources in the health care delivery system both internal and external to their practice setting.

- ***Patient Engagement:*** Providers have expressed concerns regarding being held accountable for outcomes where patient behavior may negatively influence outcomes that are ultimately linked to provider reimbursement. Nevada engages patients and increases patient accountability where permissible. Patient engagement, either through incentives or disincentives, is more promising with the non-Medicaid population. As an entitlement with no meaningful cost-sharing component, the Medicaid population engagement strategies are expected to be more challenging than those of the commercial payer population.
- ***Determination of Value****:* Payers will largely define the reimbursement structure even under value-based reimbursement models. Providers desire a voice in determining how value will be defined, measured and recognized through a payment methodology.
- ***Phased-In Approach:*** There are many unknowns when transitioning to a new reimbursement model. Nevada stakeholders have recommended and endorsed a phased-in approach that starts slowly, incorporates lessons learned and proceeds in a thoughtful manner (see *Figure 31*).

Nevada envisions evolving to a VBP methodology that recognizes quality and improved health outcomes. Initially, this transition calls for small steps that progress over time to more comprehensive models with increasing provider accountability for outcomes. Most immediately, VBP components will be part of the PCMH and MHH delivery system enhancements. Then, a review of contracts with providers and vendors will be evaluated for VBP component inclusion. Consideration of bundled or episode-based payments will follow as Nevada moves toward models with greater provider upside risks and possibly downside risks. Alignment across all parties, greater information sharing, and a fair and equitable VBP methodology that has provider and payer buy-in is essential for successful payment transformation. The PHIC will guide the implementation timeline and movement towards the following VBP models as successful implementation and transformation occurs.

Figure 31: Phased-in Approach



A. PCMH Value-Based Reimbursement

While there is consensus that implementation of the PCMH model can improve the health status of Nevada's population, there must be a reimbursement model that supports and incentivizes this transformational change. Nevada envisions a PMPM payment with additional transition to value-based payments being phased in over time.

- ***Phase I – Payment for Participation*:** Initially, PCMHs will receive a PMPM payment that recognizes the care coordination and population health management activities conducted by the provider practice, as well as a component to assist the provider in developing the practice infrastructure necessary for success. During this phase, provider payments will depend on achieving certain milestones or participation measures to ensure providers' active engagement and progress under the Nevada PCMH initiative. The achievement of the established milestones will qualify the provider for incremental payments in addition to the PMPM payment. Shared risk models will be reserved for future phases.
- ***Phase II – Payment for Reporting:*** During Phase II, providers will receive reimbursement for reporting measures. This phase will establish baseline data and the assurance that providers have developed the infrastructure and reporting capabilities to successfully participate in the value-based reimbursement program. Providers completing the reporting requirements will receive payments in addition to their base PMPM payment to recognize this accomplishment.
- ***Phase III – Payment for Outcomes:*** With successful practice infrastructure developed, and the ability to report on process, quality and outcome measures demonstrated, providers will move to Phase III, which will pay providers for achieving pre-established and communicated outcome measures. This payment will provide a bonus payment structure. This phase transitions providers from a pay for reporting to a pay-for-performance environment with only an upside to payment.
- ***Phase IV – Shared Savings:*** Once pay for performance and outcomes have been established, the Nevada approach will seek to provide an environment of shared savings. During this phase, payers and providers will establish reimbursement methodologies to include the ability of the provider to share in a portion of the savings their activities have produced. The nature of these arrangements is expected to vary widely depending on individual payers and providers; however, the general structure is planned to contain mutually agreed upon outcome measures that once achieved, result in payments that are of greater significance than the incentive payments in earlier phases. The shared savings methodologies are expected to have factors to account for normal utilization and expenditure variations, the impact of other programs or initiatives that may influence utilization or expenditures, and have maximum percentages of savings that will be shared with the provider.

After implementation of Phase IV, an assessment will be performed to determine the reasonableness and appropriateness of implementing a shared loss arrangement with providers. In this approach, actual costs that are higher than the forecasted trend would

result in a reduction in the PCMH incentive payments or a recoupment of paid funds. The entry into the phased approach may be at different times for different PCMHs, but the progression through the phases will be the same.

Nevada providers have expressed various levels of readiness to participate in a VBP model. During this planning phase, DHCFP received a proposed VBP model from one provider association. This indication that the provider community is reviewing and actively proposing models for consideration is an indicator of some degree of provider interest and willingness to participate.

B. Medicaid Health Home Value-Based Reimbursement

The number of patients participating in the MHH initiative will be relatively low compared to those participating in PCMHs. However, the value-based provider reimbursement approach for the MHH model will follow many of the same characteristics of the PCMH value-based reimbursement methodology.

Common to both reimbursement methodologies for PCMH and MHH is the use of a PMPM payment. However, the complexity of this population must be considered in creating an appropriate reimbursement methodology. The level of acuity and complexity of the medical and nonmedical needs of this population calls for a significantly higher PMPM to appropriately serve this population. Even within the health home population, there is recognition that the needs of this population will not be homogenous. Specifically, a wide array of complex needs exist among these participants. For that reason, a risk-stratified reimbursement methodology that recognizes this complexity is envisioned. A three-tiered PMPM is planned with patients being reassessed on an annual basis for movement across tiers.

Given the complex and immediate needs of the patients assigned to the MHH, health home providers are expected to possess the immediate ability to report on and generate improved outcomes. Thus, health home providers will enter the value-based reimbursement methodology at the equivalent functionality as a PCMH meeting NCQA Standard 3 (i.e., ability to collect and use data for population management). Providers will receive a risk-adjusted monthly PMPM plus an incentive payment for demonstrated outcomes.

C. Other Value-Based Payments

Episodes of Care Payments

The Delivery System and Payment Alignment Workgroup has discussed the introduction of episode-based (“bundled”) payments into the Nevada health care payment fabric. These payments will represent an all-inclusive rate for a predefined set of services rendered by a similarly defined set of health care providers. Payment for managing treatment and costs within this all-inclusive payment allows the provider to participate in a portion of the shared savings. The attractiveness of this model is due to the increased flexibility of the provider to treat the patient under a global budget for that episode, as well as the reduction in unnecessary services that do not improve outcomes.

Several legitimate concerns were voiced by stakeholders. First, the conditions for which episode-based payments are established should be appropriate for such a reimbursement model. Certain procedures occur routinely and with highly predictable components within a certain margin of variation (e.g., routine labor and delivery, knee replacement, etc.). These types of procedures are generally considered to be better candidates for episode-based payments. Episode-based payments for non-routine circumstances (e.g., trauma treatment associated with a motor vehicle accident, etc.) are not believed to be appropriate. Second, a clear and appropriate definition of what is considered to be included in the rate must be defined. Questions include:

- Which procedures/services are included?
- Which providers' services?
- Is there an outlier process for extraordinary circumstances or unavoidable complications?
- What is the end date of an episode beyond which the outcomes are considered to be separate and apart from the outcome of the episode?

Third, episode-based payments have to be structured in a way that does not incentivize providers to avoid complex patients or withhold beneficial treatments to achieve a more positive financial situation.

Sixteen Nevada sites will participate in the Bundled Payment for Care Initiative (BPCI). This Medicare initiative will link all medical services associated with an episode of care. Also, the Carson City Medicare Service Area (MSA) was selected for the mandatory chronic joint replacement bundled payment approach. Therefore, all providers in Washoe County are going to be participating in a hip-and-knee bundle for Medicare starting in 2016.[cxv] Episode-based payments will become an increasing part of the Nevada health care delivery and payment transformation effort. However, preceding fundamental components of the plan (i.e., increased access to health care data, provider infrastructure development, etc.) are believed to be factors for successful episode-based payment implementation. Therefore, episode-based payments will be introduced after the prioritized implementation of PCMHs, MHHs and a more robust HIT infrastructure in order to support providers' participation in APM-like episode-based payments.

Value-Based Purchasing Review of Contracts

Particularly with Medicaid and CHIP plan administration, much of the interventions and work to improve population health occurs through the assistance of contracted vendors. In Nevada, two types of contracts are noteworthy in this respect. First, the Medicaid MCO contracts held with two vendors who serve approximately 320,000 Nevadans in Clark and Washoe counties through a fully-capitated, risk-based contract. The second relevant contract is with a single CMO that delivers care and case coordination services for almost 42,000 Medicaid enrollees in the Medicaid FFS program.

As part of the payment transformation and alignment process, a review of these key Medicaid contracts will be conducted. This review will focus on opportunities to align the

state's transformation priorities and focus areas with these key contracts. The MCO and CMO contracts offer powerful levers to produce the results desired by Nevada. Aligning these contracts with the desired results and introducing a value-based contracting approach stand to offer the financial incentive to vendors to reach those common objectives. Lessons learned and opportunities realized through this effort will be shared with other payers to facilitate their migration to a value-based contracting arrangement that aligns with the state's population health objectives.

VIII. POPULATION HEALTH PLAN

In order to prioritize population health improvement opportunities, research on Nevada population health statistics was conducted. The leading causes of morbidity and mortality in Nevada as well as the anticipated approaches to address those needs are outlined in this section.

A. Leading Causes of Morbidity and Mortality

Nevada currently ranks 47th in the U.S. for overall health and spends an estimated $20 billion annually for chronic disease care alone. *Figure 32* shows the top 10 leading causes of death in Nevada and the attributed mortality rate per 100,000 deaths compared to the U.S. mortality rate, along with pertinent statistics regarding related expenditures and national ranking.[cxvi]

Figure 32: Leading Causes of Death in Nevada

Disease	2013 Nevada Death Rate *(Per 100,000)*	2013 United States Death Rate *(Per 100,000)*	Pertinent Statistics
Heart Disease	195.1	169.8	Nevada ranked 33rd in the nation for prevalence of heart disease in 2014.[cxvii]
Cancer	164.7	163.2	Nevada's annual health care costs of care for cancer totaled $750 million in 2011.[cxviii]
Lung Disease	54.1	42.1	Nevada's health care costs directly associated with smoking totaled $1.08 billion in 2013.[cxix]
Accidents	41.9	39.4	Unintentional injuries are the leading cause of death for Nevadans ages 1 to 44 years.[cxx]
Stroke	33.3	36.2	Nevada ranks 36th in the U.S. for occurrence of stroke.[cxxi]
Suicide	18.6	12.6	Nevada ranks 7th in the U.S. for suicides.[cxxii]
Influenza/ Pneumonia	18.6	15.9	Nevada's health care costs associated with pneumonia exceeded $10 billion in 2011.[cxxiii] In 2012, Nevada ranked 51st in the U.S. for influenza immunizations in the elderly.[cxxiv]
Alzheimer's Disease	18.4	23.5	The cost of care for Alzheimer's and dementia is estimated to be $226 billion for 2015, increasing to $1.1 trillion by midcentury.[cxxv]
Diabetes	14.8	21.2	Nevada's direct medical expenses for diabetes (diagnosed and undiagnosed) were estimated at $1.9 billion in 2012.[cxxvi]
Liver Disease	12.9	10.2	In 2013, Nevada ranked 17th in the U.S. for binge drinking.[cxxvii]

Centers for Disease Control and Prevention. "Deaths: Final Data for 2013." National Vital Statistics Report. Volume 64, Number 2. Forthcoming, [Accessed: January 22, 2015]. Available: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

Seven of the 10 leading causes of death in Nevada are chronic diseases. Many chronic diseases share a common characteristic: a significant number of them are preventable or can be reduced in severity through routine access to preventive services and active patient engagement leading to changes in personal lifestyle behaviors. Also, chronic diseases are not mutually exclusive. One is often a risk factor for another. The most prevalent chronic diseases amongst the Nevada population are obesity, arthritis, diabetes, cancer, chronic obstructive pulmonary disease (COPD), heart disease and stroke. The Nevada prevalence of these conditions is represented in *Figure 33*.

Figure 33: Prevalence of Chronic Disease in Nevada

Chronic Condition	Overall Adult Prevalence
Overweight or Obese	60.2%
Arthritis	22.9%
Cancer	11.2%
Diabetes	10.3%
Chronic Obstructive Pulmonary Disease	7.3%
Heart Disease	4.1%
Stroke	3.1%

Source: "Burden of Chronic Disease in Nevada." April 2013. Department of Health and Human Services, Nevada State Health Division Chronic Disease Section. www.leg.state.nv.us

The modifiable health behaviors that are pivotal in chronic disease prevention and successful treatment include physical activity, nutrition, tobacco use and alcohol consumption. Each of these can affect the development and progression of numerous chronic disease states. Physical activity is one of the most important behaviors influencing health. The risks of obesity, Type 2 diabetes, depression, cardiovascular disease and some types of cancer may be associated with a lack of sufficient exercise. According to UnitedHealth Foundation's America's Health Ranking's survey, 23.6 percent of adults surveyed in Nevada report no participation in any physical activity during the prior month.[cxxviii] In the same survey, when asked about adherence to a healthful diet and regular exercise, 35.6 percent of adults in Nevada report eating less than a single serving of fruit daily, and 20.8 percent report eating less than a single serving of vegetables daily. Modifiable individual behaviors and increased responsibility for individual health are emphasized through various components of the SHSIP.

Through a review of the Nevada health care delivery system, and input from providers, consumers and other stakeholders, various needs and solutions have been identified to improve population health of Nevadans. The following chronic diseases and conditions are considered high priorities for Nevada to address based on population-wide prevalence, overall health burden and associated cost. Nevada will utilize the health care delivery system and payment transformation elements in this plan to positively impact population health as measured by national standards and metrics.

Cardiovascular Disease

Nevada ranks 36th out of all states in cardiovascular deaths, 26th in heart attack prevalence and 10th in cardiovascular disease prevalence.[cxxix] As the leading cause of deaths in Nevada, cardiovascular disease accounted for over 25 percent of all deaths in the state in 2013.[cxxx] This data also reveal that lower-income, black citizens are disproportionately likely to die from cardiovascular disease. Coronary Artery Disease (CAD) is the most common form of cardiovascular disease and the leading cause of death in Nevada. CAD costs the U.S. approximately $108.9 billion per year. The CDC's 2013 mortality data document 195.06 deaths per 100,000 in Nevada due to cardiovascular disease as compared with 169.77 deaths per 100,000 averages for the United States.[cxxxi] Incidence of stroke as the cause of death was actually less in Nevada, with a rate of 18.39 per 100,000 population as compared with a national rate of 23.52 per 100,000 population. A significant percentage of the U.S. population who experience a myocardial infarction, heart failure or stroke will develop a chronic disability. This further increases the losses in productivity as well as significantly reducing the quality and in the majority of cases, the longevity of these individuals.

Chronic Pulmonary Disease

The third leading cause of death in Nevada is Chronic Pulmonary Disease, a condition directly associated with tobacco use. Almost one-third of all cardiovascular deaths are attributable to smoking. In 2012, 3,430 deaths in Nevada were attributed to smoking-related diseases, with 1,049 due to respiratory disease.[cxxxii] The CDC has noted that smokers are 12 to 13 times more likely to die from COPD than nonsmokers.[cxxxiii] According to the Nevada DPBH, the costs attributable to smoking for adults in Nevada is estimated at $1.4 billion, including annual health care costs of $565 million and $832 million in costs related to loss of productivity, an average cost of $2,395 per smoker. The Nevada 2014 *Behavioral Health Barometer*, published by the Substance Abuse and Mental Health Services Administration, noted that the rate of cigarette use in adolescents aged 12 to 17 was 6 percent as compared with the national average of 6.1 percent.[cxxxiv]

The results of tobacco use and exposure are not limited to chronic pulmonary disease. Tobacco use is also a risk factor for the development of cardiovascular disease, the leading chronic disease state and cause of mortality in the U.S. and Nevada. Additionally, use of tobacco during pregnancy increases the risk for low birth weight babies, premature birth, Sudden Infant Death Syndrome (SIDS), asthma and childhood obesity. Cigarette smoking causes the majority of lung cancers, and other cancers such as bladder, colon, esophageal, larynx, stomach, pancreas, oropharynx and kidney, and leukemia may be linked to smoking as well.

Behavioral Health

Behavioral health encompasses both mental health and substance use disorders. Mental health issues are one of the major concerns in evaluating Nevada's potential for improvement in the provision of quality health care. The suicide rate in Nevada is one of the highest in the nation, and suicide is the sixth leading cause of deaths in Nevada.[cxxxv] On average, one person dies of suicide in Nevada every 16 hours, and 90 percent are suffering

with some sort of mental illness, most commonly depression. In addition to the immeasurable cost of lives, suicides, in 2010, resulted in $593,140,000 of combined medical and loss of productivity costs to the state.[cxxxvi] In 2012, the Nevada veteran suicide rate was 74 percent higher than the national rate of 12 deaths per 100,000 persons. Suicide is the second leading cause of death in Nevada youth ages 15 to 24.[cxxxvii] For example, in Washoe County in 2013, 21 percent of teens in high schools considered suicide, and 14 percent attempted it. As in other areas of the country, the suicide rate in the Native American youth population is disproportionately high and probably falsely underestimated, as many individuals who identify themselves as Native American are not recorded as such on their medical record.

Adolescents in Nevada have significant behavioral health needs. These are easily recognized upon review of pertinent statistical data. A SAMHSA survey done for 2012-2013 reported:

- 9.6 percent of Nevada adolescents (ages 12 to 17 years) had at least one major depressive episode within the year prior to being surveyed.
- 10.2 percent admitted to using illicit drugs
- 5.7 percent reported using cigarettes within the month prior to being surveyed.
- 61.4 percent perceived "no great risk" in having more than five drinks of alcohol once or twice a week.
- 77.6 percent perceived no great risk in smoking marijuana once per month.
- The percentage of adolescents reporting improved functioning from treatment received through the public health system was greater in Nevada than that in the nation as a whole.[cxxxviii]

Obesity

In 2014, according to America's Health Rankings, 26.2 percent of all Nevadans were considered "obese," defined as a BMI of 30 or higher.[cxxxix] The rate of adult obesity was 27.7 percent of the population, ranking Nevada 35th in the U.S. for adult obesity. The Nevada childhood obesity rate is 12.7 percent for ages 2 to 4 years (2011 data), 18.6 percent for ages 10 to 17 years (2011 data), and 11.4 percent of high school students (2013 data). Further evaluation of the data shows a racial disparity with a rate of 26.4 percent in the populace, 27.8 percent in Latino, but 37.1 percent in the African-American population.[cxl]

Diabetes

In 2012, the estimated total cost of diabetes in Nevada per year exceeded $1.5 billion, including lost work productivity costs and direct medical bills.[cxli] The 2012 BRFSS data noted a disparity in the prevalence of diabetes based upon income levels, with those individuals with an income of less than $15,000 per year having a prevalence rate of 11.1 percent compared with a prevalence rate of 6.4 percent in the population with income levels greater than $75,000 per year.[cxlii]

Access to quality health care remains an issue in Nevada. This does not include just the ability of the patient to physically reach a provider, but also the ability to obtain appropriate care from the provider. 2012 BRFSS data showed that only 65.7 percent of Nevada adults with diabetes had their A1c measurement of blood sugar control checked at least twice within a year as recommended by the American Diabetes Association (ADA). Additionally, only 59.7 percent of Nevada adults with diabetes had been checked within a one-year period for lower extremity issues, 56.2 percent had an eye exam within 12 months of the survey and 53.1 percent of adults with diabetes had taken a course on how to manage diabetes.[cxliii]

Cancer

Nevada's top five cancer mortalities are lung, prostate and breast cancer, along with colon and pancreatic cancer.[cxliv] While not entirely preventable, the incidence of lung cancer is drastically reduced with the avoidance of risky behaviors such as smoking, and the mortality rate associated with breast, prostate and colon cancers is reduced with adherence to regular screening protocols.

Prenatal Care/Birth and Early Developmental Outcomes

In 2012, 8 percent of babies in Nevada were born with a "low birth weight."[cxlv] Low birth weight babies are at risk for long-term disability and impaired or delayed motor and social development. In addition, 77.3 percent of low birth weight babies have health problems that require specialty care in NICUs.[cxlvi] Studies have shown that Medicaid pays four times more for newborn care in the NICU than payments for nonspecialty newborn care.[cxlvii] Risk factors include inadequate maternal weight gain and smoking during pregnancy. Smoking during pregnancy is associated with intrauterine growth retardation, premature birth, stillbirth and infant mortality, as well as developmental delay in infancy.

Postnatal care for the mother is extremely important not only for the welfare of the mother but also for the child. It is estimated that 30 to 70 percent of women experience postpartum sadness immediately after delivery, and 10 percent suffer with significant depression. Post-partum depression has been associated with adverse effects on the development of the mother-child relationship and infant behavior.

B. Social Determinants of Health

The health concerns in Nevada are not only numerous, but complex, with issues of provider deficit, socioeconomic and cultural disparities, inordinate travel distances for services and poor access to healthy lifestyle options—all posing challenges to population health improvement efforts. According to the World Health Organization, social determinants of health include social and economic environment, physical environment, and individual characteristics and behaviors.[cxlviii] These include the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Individuals operate along a natural hierarchy of needs working to fulfill most basic needs first. The Healthy People 2020 report describes the five key areas of social determinants of health as economic stability, education, social and community context, health and health care, and neighborhood and built environments.

The revised Nevada health care delivery system must recognize the importance of these five key areas of social determinants of health. This approach will challenge many providers and payers to think outside the traditional medical model when assessing and developing treatment plans and health plan benefit designs for their patients.

C. Approach to Population Health Improvement

Through research and strong stakeholder engagement, the DHHS approached the SHSIP population health plan with an understanding of the most prevalent disease states and health priorities in mind. Nevada will utilize the health care delivery system and payment reform tools outlined in the Delivery System Transformation section of the SHSIP to positively impact these population health opportunities. These tools will be supported by a strong, statewide HIT Plan also described in the SHSIP, with a key purpose of ensuring timely patient information is available at the point of care. In discussing the population health plan, population health strategies are grouped into three categories representing the level of influence at the provider and community level:

- Traditional Clinical Approach
- Innovative Patient-Centered Care Approach
- Community Level Health Approach

Traditional Clinical Approach

Clinical Practice Guidelines

Through the work of the PHIC, the Outcomes Committee will review and endorse nationally recognized clinical practice guidelines (CPGs) and best practices. These guidelines will become the common statewide expectation that providers are encouraged to follow. Through the MPC, payers will utilize these standards to communicate a unified expectation of providers. The common framework that these guidelines establish will promote a consistent message to providers regarding the PHIC's expectations and measures that will be applied to monitor improved outcomes. Additionally, this framework will establish a common platform from which value-based reimbursement methodologies will be based.

Standardized Quality Metrics

The PHIC will review the body of nationally recognized quality and outcome tools and measures. Having representation that includes both providers and payers, the measures by which provider success will be evaluated will be established by input from both parties. A common set of quality measures aligned across all payers reinforces the top priorities and expected outcomes that payers may choose to include in VBP methodologies.

The PHIC is expected to adopt measures that do not create an undue burden on the provider. Numerous quality measures are already required for reporting for MU purposes under the Medicaid EHR incentive program as well as by other entities. Adoption of quality and outcome metrics that providers are largely already reporting on or have the ability to report on permits providers to report measures without significant additional administrative burden.

Point of Care Information Availability

Point of care diagnosis and treatment decisions require access to complete and timely information regarding the patient and the patient's health care experiences. Information such as other diagnoses, previous treatment regimens, lab results, radiology and imaging findings, admissions/discharges/transfers, case manager notes and pharmacy data will be made available through the HIT infrastructure discussed in the HIT Plan section of this document. Among the expected results are: more accurate diagnoses, better informed treatment plans, elimination of unnecessary tests or procedures, better inpatient discharge planning, and reduced costs due to removal of redundancies and inefficient or ineffective treatments.

Better information at the point of care also will be facilitated through the use of HIT. Using technology to identify care gaps for disease states or complex conditions identified and vetted through the PHIC, providers will receive push messages to drive the provider toward patients who have care gaps or other opportunities for improved management of their health condition. Developing and deploying this technology in a manner that integrates with the existing provider EHR and practice software without creating administrative burdens or prohibitive costs is a key consideration.

Innovative Patient-Centered Care Approach

Patient-Centered Medical Homes

Both the PCMH and the MHH models as described in the Health Care Delivery System Transformation section will provide coordinated care among providers with the shared goal of improving patient care and outcomes for an attributed set of patients. Physicians, extenders, care managers and other staff will redefine work flows and responsibilities as practices incorporate PCMH elements into their practice, as well as for coordinated care teams under the MHH initiative. Licensed providers will be encouraged to practice within the fullest extent of their permitted scope of practice and will be supported by a growing Nevada HIT infrastructure.

PCMHs and MHHs are expected to drive improvements in Nevada's population health through:

- Greater patient-provider engagement
- Promotion of wellness, prevention and early intervention
- Improved coordination of care
- Enhanced patient engagement
- Increased provider adoption and utilization of EHRs and exchange of patient health information across the statewide HIE
- Stronger integration of physical health and behavioral health needs and treatment
- A more holistic view of the patient by recognizing the importance of social determinants on health

Super-utilizer Program

Nevada will develop a common definition to identify super-utilizers and utilize the PCMH and MHH models to provide intensive care coordination delivered by an interdisciplinary team of health care professionals. This team will be cognizant of the social determinants of health and their impact on the individual. The physician-led team will incorporate a holistic treatment approach.

As discussed in the Delivery System Transformation section, these individuals represent a small percentage of the population but represent a significant portion of the costs. The intensive coordination offered by the super-utilizer program is expected to: address the socioeconomic needs of individuals so they can focus on their health, increase the use of primary care, assist the patient with appropriate utilization of health care resources, encourage patient engagement and decrease overall costs.

Community Health Workers

Under the Nevada plan, CHWs will serve a critical role in bringing the individual to the health care delivery system. CHWs are trusted individuals in the community who "meet people where they are." CHWs identify individual needs across the medical and nonmedical spectrum that contributes to health and wellness. They help connect individuals with medical and nonmedical services and supports to move the individual toward better health.

Through the stakeholder engagement process, DHCFP heard repeatedly that CHWs are especially needed to help the Medicaid expansion population properly access health care services. Prior to Nevada's Medicaid expansion, these individuals largely accessed routine health care services through the ED. While inappropriate, this was the only option for many of these individuals who could not pay for medical care. This lack of access to primary and preventive care meant that individuals presenting at the ED were often of higher acuity levels when they accessed care. This higher acuity level, avoidable complications of the conditions and expenditures could all have been reduced with proper access to care.

Due to early success in Nevada with the use of CHWs on a small scale, the number of CHWs and their scope will be increased. The SHSIP contemplates CHWs will:

- Serve as a liaison between individuals and community entities, health care agencies, services and payers to gain appropriate medical, behavioral and social services
- Provide guidance and social assistance to individuals, which will assist in attaining health care services
- Provide culturally and linguistically appropriate health or nutrition education to citizens
- Advocate for individual and community health
- Provide referral, follow-up and coordinate care

Discussions are also underway to utilize CHWs to provide certain direct services under the direct supervision of a licensed health care professional. These direct services may include:

- Glucose screening
- BMI screening
- Cholesterol screen/finger stick
- Vital signs, including blood pressure, body temperature, pulse rate, respiration rate and/or pulse oximetry
- Fluoride varnish application
- Rapid HIV screening
- Immunizations
- Developmental screenings
- Health risk screening

The final role and success of CHWs in Nevada will be a combination of the DHHS final rules, payer recognition of the resource and the ability to produce a quality workforce of CHWs sufficient to meet the needs of Nevada. The PHIC will be a strong lever to promote payer evaluation and adoption of CHWs as an integral part of the health care delivery system. Payer adoption must be accompanied by a reimbursement methodology to ensure sustainability of this resource in the delivery system. The potential ROI of CHWs is addressed in the financial section of the sustainability plan. Early investments—even if small—stand to promote savings that can be reinvested in CHW workforce development and expansion.

Nevada does not envision CHWs as a stand-alone resource. CHWs must function as an integrated part of the health care delivery system. CHWs will be connected with the PCMH or MHH and will be able to input notes electronically into the patient's treating providers' EHRs. The information and real world details of the patient's situation must be conveyed and incorporated into the comprehensive treatment plan.

Community Paramedicine

Nevada will promote the use of community paramedicine in the health care delivery system. Nevada will draw upon two Nevada community paramedicine programs' successes and work to expand and replicate this effort in the state.

As part of the plan, education regarding community paramedicine and its role in the health care delivery system will be developed with multiple intended audiences. These audiences include payers, providers and the general public. This education will facilitate payer recognition of the opportunity for community paramedicine to improve health outcomes and decrease costs. The role that paramedicine professionals will play may include: follow-up on at-risk patients after a discharge from an in-patient facility to a home or community environment; medication reconciliation; obtaining vitals and possibly lab specimens; rapid result testing for disease control, such as glucometer readings or rapid blood thinner levels; environmental scan of the home environment; promotion of health literacy and patient understanding of their health condition; diversion during transport to the most appropriate

care setting; referral to a CHW to address access to care or other needs; and the conducting of community-level education programs.

Community paramedicine programs will become part of the patient-centered health care delivery system and individualized patient treatment team. Physicians will need to understand the availability and potential benefit of using this resource. Community paramedics are uniquely positioned to reach patients in their home environment when patients do not have transportation to access care, are noncompliant with follow-up care, or there are risks in patients accessing physician care in an office environment (e.g., immunocompromised, fall risk, etc.). The encounter of the paramedic in the home environment will be documented and communicated back to the care delivery team electronically to be stored in the patient's EHR and ultimately shared through the HIE.

Expansion of the Nevada community paramedicine program will improve access to care, inappropriate utilization of the ED, hospital readmission rates, patient health literacy and engagement, health outcomes, and will decrease cost. Additionally, paramedics will be used as a trusted local resource that can conduct community education on certain health, wellness and prevention topics pertinent to that community.

Telemedicine

As referenced throughout this plan, access to health care services in Nevada has its challenges, both from the standpoint of the number of providers and the geographic availability of those providers. The number of telemedicine sites as well as payer acceptance and reimbursement methodologies to recognize telemedicine as a care delivery modality are focus areas of the Nevada delivery system reform. Increasing the number of telemedicine sites and payer acceptance will improve access to treat all of the chronic conditions and improve access to prevention. Early intervention with conditions identified through this process is expected to change the trajectory of the disease, improve outcomes and decrease long-term complications. Each of these improvements is expected to decrease expenditures over time.

Project ECHO

The population health improvement plan will leverage and expand Nevada's existing Project ECHO program. An education and awareness campaign will be conducted to improve provider understanding of this resource, which will connect PCPs with specialists and resources with expertise in certain disease states. This program benefits patients through greater access and PCPs through professional development and professional gratification.

In aggregate, specialist access is limited in Nevada. Coupling this limited supply with geographic and transportation issues, patients may go without proper diagnosis, treatment or follow-up. Expanding Project ECHO will bridge some of these gaps and improve access to care for many Nevadans. Earlier and more appropriate patient diagnosis, treatment and follow-up address access to care issues, stand to improve outcomes, modify the rapidity of disease progression, lessen acuity levels, decrease unnecessary health care resource utilization and decrease costs.

The consultative services and education carry its own benefits to the PCP presenting the patient. Project ECHO gives the remote PCP the opportunity to learn and develop specialized skills in treating certain complex disease states. These specialized skills open a new niche for the provider's practice, which may result in that provider increasing their patient base for individuals with that condition. In addition to creating additional access points for care, Project ECHO also stands to increase professional satisfaction from the participating PCP.

The PHIC will work to develop a strategy for the education campaign and mechanics of this expansion. The availability of the services, ensuring low administrative burdens to participate and establishing a financing mechanism to support the expansion and adoption of Project ECHO will be included in the PHIC's charge.

Patient Engagement

Nevada will seek greater patient engagement through improving health literacy, providing education and measuring the patient's perspective of their experience with the Nevada health care delivery system. Health literacy and education efforts will benefit from a number of elements in this plan. These include:

- An increased number of PCMHs or providers operating with key elements of a PCMH
- Outreach by CHWs
- Education from community paramedicine professionals
- Payer and local efforts to reach communities and leverage existing DPBH initiatives
- Utilization of a patient HIT portal that will offer patients the opportunity to learn more about their disease state or health, wellness and prevention in general and to create and maintain an electronic, personal health record

The CAHPS and other nationally recognized tools will be evaluated by the PHIC to determine the most appropriate survey tool to measure patient experience. The PHIC will work to promote survey completions and explore incentive opportunities that may improve survey response rates.

Community Level Health Approach

Health Interventions

Addressing population health issues and topics is the goal of community-level health interventions. These interventions target a large number of individuals who stand to benefit from the message. In Nevada, the PHIC will work with its participating members to ensure the community-level intervention and efforts are consistent with the driving needs and opportunities to improve Nevada's population health. These efforts must be closely coordinated with the Nevada DPBH, and the efforts should leverage the expertise, programs and resources available through the DPBH.

Education

The PHIC will solicit and identify individuals or organizations in local and regional areas that will serve as liaisons and champions of health of community-wide health education campaigns. Initially, the health plans participating in the MPC are expected to utilize their staff or other local or regional staff to spearhead these efforts. These local staff will work with the PHIC and the DPBH to establish priority health education campaigns. Messages, materials and resources will be reviewed to ensure alignment with the population health goals, consistency in messaging and maximizing the use of existing tools and resources. Community-wide educational campaigns are envisioned to include an emphasis on modifiable risk factors and individual actions that can be taken to mitigate those risk factors.

Youth Focused

The SHSIP recognizes the importance of wellness, prevention, early intervention—especially in the youth population. The driving costs and utilization patterns of typically older patients with chronic conditions will not distract Nevada from recognizing the importance of addressing the needs of the youth population and addressing their risks and needs at an early age. Population health will be improved through a number of different interventions geared toward the youth population, including:

- ***Pregnancy:*** Payer and DPBH MCH programs will be leveraged to promote proper pregnancy planning and prenatal care. Influencing pre-pregnancy factors such as birth spacing, healthy behaviors and lifestyle modifications, use of folic acid, etc., will be encouraged through the public health programs, payers and providers. Proper prenatal care and compliance with obstetrical visits will be promoted as well in efforts to promote healthy deliveries of normal birth weight babies. These healthier pregnancies and deliveries will improve the health status of Nevada's children and decrease unnecessary costs associated with avoidable high-risk pregnancies, neo-natal intensive care stays and other high-end medical resources.
- ***Well-Child Visits****:* Payers, providers and the PHIC will work together to promote patient compliance with well-child visits consistent with the periodicity schedule for children according to their age. Ensuring that all required components of the well-child visit are performed during the encounter also will be reinforced.
- ***Immunizations:*** Nevada will leverage DPBH resources and the unified voice of the PHIC to educate parents on the importance of immunizations in preventing or mitigating certain conditions. The HIT infrastructure will be utilized to notify providers of care gaps, provide notices to parents through the patient portal, encourage patient education, and scheduling of office visits. Opportunities for mass immunizations through school settings will be explored.
- ***Behavioral Health:*** Nevada will focus on proper utilization of psychotropic medications and appropriate follow-up. The utilization of psychotropic medication by youth will be monitored to ensure proper use, according to Food and Drug Administration (FDA) labeled indications, ages and dosing regimens. Follow-up appointments at periodic intervals supported by the clinical literature and standards of practice will be endorsed and communicated through the PHIC. Population health

measures to ensure compliance and improvement will be monitored and publicly reported.

- Nevada also will address youth-based behavioral health needs through promoting the integration of behavioral and physical health care services for youth. This effort will leverage the National Governors Association (NGA) Medicaid Transformation project in Nevada, which seeks to transform the behavioral health system for Nevada's youth (ages 11 to 18 years) from a crisis-based service system to a system of prevention and early intervention. While not youth-specific, the recent SAMHSA award to Nevada under the CCBHC grant will also help improve the youth population's behavioral health outcomes promoting the integration and introduction of a value-based reimbursement system to accelerate improvements.
- With suicide being the second leading cause of death in Nevada for youth ages 15 to 24 years of age, Nevada will deploy methods to address this issue.[cxlix] Recommended screening tools, frequencies and forums will be discussed and determined by the PHIC and communicated statewide. Improvements to the timely referral and access to the necessary counseling and support services will be made. The increased use of telemedicine under the plan provides one opportunity to improve this access. Promoting workforce development of APRNs with a psychiatry designation also will assist with improved access. The administrative simplification to provider licensure discussed in the plan also stands to help improve the likelihood of behavioral health providers seeking reciprocity in Nevada from surrounding states, thus improving access. The use of mobile applications that a youth with suicidal ideations could access for help will be reviewed by the PHIC and promoted as well. The work of the NOSP will be leveraged and supported as strategies are deployed and evaluated. Improved provider training efforts will be developed, which also supports the requirements of Nevada AB93, which mandates two hours of suicide prevention training for behavioral health providers with recertification.

Leveraging DPBH Programs

The plan calls for leveraging of existing DPBH programs. Through the stakeholder engagement process, a number of public health programs have been identified that will be leveraged. A few examples of these programs and how they will be used include:

- ***Nevada Tobacco Quitline:*** The Quitline offers counseling and nicotine replacement for individuals seeking to quit smoking. This resource is available to all Nevadans free of charge. The PHIC will explore opportunities to utilize the Quitline and find avenues to support the Quitline. Public awareness of this resource through community level interventions and efforts will be explored by the PHIC.
- ***Heart and Stroke Prevention and Control Program:*** This DPBH program seeks to positively impact the premature death and disability from heart disease and stroke among Nevadans through:

- Prevention, detection and treatment of heart disease and stroke risk factors
- Prompt and early detection and treatment of heart disease and stroke
- Elimination of disparities in heart disease and stroke care

These activities are aligned with the national Million Hearts initiative to prevent 1 million heart attacks and strokes in five years. Utilizing the community engagement and awareness activities initiated by this group, education and awareness regarding cardiovascular disease prevention, treatment and early identification of an event will be leveraged through the PHIC. The PHIC will promote common messaging and clinical practice guidelines related to these conditions.

- ***Obesity Prevention and Control Program:*** This program connects Nevadans with strategies to address healthy body weight and obesity prevention. Community awareness of the services offered through this program will be promoted through the implementation of the plan. The PHIC will be educated on the available resources through this program, and the PHIC will work to leverage these resources across payers. Providers also will receive education regarding the program and its availability as a resource.
- ***Diabetes Prevention and Control:*** The PHIC will leverage the DPBH Diabetes Prevention and Control program, which seeks to reduce disease, disability and death related to prediabetes and diabetes. The resources available through this unit will be leveraged to:

  - Strengthen professional and public education for diabetes prevention and control
  - Foster diabetes prevention education and diabetes self-management education
  - Increase the links between community and clinical resources to support prevention, self-management and control of diabetes, and improved outcomes

  These resources address diabetes at the state, regional and local levels and will be leveraged and supported in implementing the SHSIP.

- ***Nevada 2-1-1:*** Nevada currently operates Nevada 2-1-1, which is a free service that provides information about vital health and human service programs that are available throughout the state. Information and referral professionals are available any time, day or night, to assist citizens with locating needed services within their Zip code area. The Nevada 2-1-1 system currently includes information to assist with needs, such as:

  - Physical and mental health needs
  - Financial stability
  - Resources for older individuals and persons with disabilities

- Children, youth and families
- Community crisis and recovery resources
- Other basic needs

The Nevada 2-1-1 system serves a much needed role in supporting population health improvement. This free, statewide system assists individuals with connecting with medical and nonmedical needs that influence health and outcomes. This system stands to connect individuals with resources to fulfill basic needs (e.g., housing, financial support, etc.) that must be addressed before most individuals can focus on health and health improvement. The SHSIP seeks to leverage and support Nevada 2-1-1 by promoting the listing of community resources to increase the robustness of the database, promoting provider awareness and referral of patients to the resource, and utilizing the database as CHWs and providers help individuals navigate the health care system and fulfill basic needs.

The sustainability of the Nevada 2-1-1 system also must be addressed. Nevada 2-1-1 operates under an Executive Order that expired on December 31, 2014, and it is currently operating under a memorandum of understanding between the DHHS and its operational partners. Long-term sustainability in terms of authority as well as financing will be pursued under the SHSIP.

Connecting individuals with Nevada 2-1-1 is expected to improve population health through mitigating social determinants of health and improving access to care through identifying both physical and behavioral health providers and services.

HIT Infrastructure

As discussed in the HIT Plan, part of the Nevada solution involves deploying a HIT solution that public reports on population health measures. This public reporting tool is planned to include the ability to drill down to various geographic levels. This tool will be important in monitoring population health progress and opportunities in various communities. The reporting tool also is planned to have the ability to drill down to other levels based on factors such as age, gender, race, ethnicity, household income, etc. Identifying population health needs by communities and subgroups will assist with identifying local and specific needs, intervention opportunities, health disparities and strategies to address those needs. All of these factors will help drive population health improvement at a community and state level.

D. Population Health Measurement and Aims

Nevada will align current efforts to influence the priority population health concerns. The first step to align the multiple initiatives will be to establish a common mechanism for measuring progress. The driver diagram establishes process measures to assess progress on building the necessary infrastructure. The HIT infrastructure will support the ability to move from process measures to population health outcomes measures derived from EHRs and population health registries.

The clinical and population measures in *Attachment G* provide the clinical quality measures that have been recommended by the Clinical Outcomes and Quality Workgroup during the

stakeholder engagement process. These measures are a starting point for the Outcomes Committee of the PHIC to consider as consensus is ultimately reached between the payers and providers. Consensus on these measures will provider uniform performance measures, which will be used to assess performance and incorporated into the individual payer value-based reimbursement methodologies. It is envisioned that this list of metrics will grow and change over time as the infrastructure matures to support EHR-generated measures at the population level.

IX.WORKFORCE DEVELOPMENT STRATEGY

Many current innovations in Nevada were brought forth throughout the stakeholder engagement process that have a proven ability to transform health care and make a difference in the lives of Nevadans by expanding access to appropriate care. Community paramedicine, CHWs, legislative progress toward telemedicine recognition, as well as the state's use of Project ECHO are among the initiatives that will be expanded in Nevada. In an effort to close the increasing gap between the number of health care professionals and the number of people needing care, alternative methods of care and expansion of the health care workforce are necessary. Workforce development for Nevada will include expanding the roles and functions of nonclinical and nontraditional providers as well as actively promoting the full scope of practice of existing providers.

Community Paramedicine

Community paramedicine permits paramedics to use their training and skills in non-traditional ways throughout the community and outside the typical emergency response model. Community paramedics may practice medicine using a special set of skills and protocols beyond that for which they were originally trained.

Additionally, community paramedicine workers triage and transport patients to places other than the ED based on clinical needs. Examples include transport to urgent care facilities for patients with nonemergency conditions, transport of medically stable inebriated patients directly to an appropriate facility and transport of medically stable psychiatric patients directly to mental health facilities.

In 2011, Humboldt General Hospital in Winnemucca implemented Nevada's first comprehensive community paramedicine program. The Humboldt model integrated community paramedics into a number of the hospital's inpatient and outpatient clinical care departments, including primary care and prevention, radiology and other diagnostic services, and cardiopulmonary care and rehabilitation. Community paramedics at Humboldt General Hospital are working to improve the overall health of the community by helping Humboldt County residents manage chronic conditions, and are being utilized to help rural residents prevent illness and disease through immunizations, health education, in-home risk assessments and preventive screenings. Lastly, community paramedics at Humboldt are extending the capabilities of hospital physicians by providing in-home care under physician's orders and follow-up visits to patients who have been discharged from the hospital.

Similarly, in Washoe County, REMSA conducted a three-year paramedicine pilot program under a CMS Health Care Innovation award. Today, patients have 16 participating alternative destinations that include urgent care centers and clinics. The REMSA program continues to add other medical facilities as alternatives to ED care. It is important to note that these paramedics are specially trained and follow strict, locally developed protocols for triage.

Nevada has two successful paramedicine pilots, REMSA and Humboldt General EMS Community Paramedicine Services, whose experience will be leveraged to incorporate paramedicine into the larger health care delivery system. The REMSA pilot was initially funded through a $9.9 million Health Care Innovation Award grant sponsored by the CMMI. The grant required an operations plan, self-monitoring plan, measurement strategy and an independent evaluation among other requirements. The REMSA Community Health Paramedics program allows in-home services with the goal of improving the transition from hospital to home. The pilot program offers services such as medical care plan adherence, medication reconciliation, point-of-care lab tests and seeks to improve patients' health literacy. Between June 2013 and June 2015, just fewer than 1,000 patients were enrolled in the program. REMSA reported the following preliminary results:

- 269 ED visits avoided
- 175 ambulance transports avoided
- 102 readmissions avoided
- $1,906,858 in estimated savings

The success of the paramedicine program is dependent upon the triage performed by a paramedic in the field at the time of the response to the occurrence. The paramedic performs an assessment and determines, with the patient's help, if the patient can be best served at another location other than the ED. Once that determination is made and the patient consents to transport to another facility, the location is checked for hours of operation and acceptance of the patient's insurance.

The REMSA program includes a highly successful Nurse Health Line that provides 24/7 assessment and referral to appropriate community services via telephone to all residents of the county. The REMSA Nurse Health Line uses the Emergency Communications Nurse System (ECNS) Protocol, which allows the nurse to lead the caller through a set of questions designed to identify a recommended course of care appropriate to each health assessment. Community services linked to the system allow the nurse to identify a location of care for the patient other than the ED. The Nurse Health Line is fully integrated with the 9-1-1 system, allowing patients to be directly transferred to the Nurse Health Line instead of having to call another number.

Additionally, the REMSA model includes a community paramedicine program that treats patients in the home, providing post-discharge follow-up and improving the transition of care from hospital to the home. These specially trained individuals offer support and testing of the patient in the comfort and security of their own home. The community paramedics provide post hospital discharge follow-up that promotes discharge plan protocol compliance and reassurance to the patient in a potentially stressful time.

Recently adopted legislation regarding the paramedicine role in health care has shown Nevada's commitment to continuing these roles. As a result of AB305, Chapter 450B of the NRS was amended to allow for the provision of an endorsement to the ambulance service

license that allows for community paramedicine services in all Nevada counties, and AB426 expanded the definition of "provider of health care" to these services.

The use of paramedicine in Nevada and in other parts of the country (see the sustainability discussion of *Section X*) has successfully improved appropriate utilization of health care resources and improved outcomes. Nevada's two current paramedicine programs serve as a tool to address access issues and mitigate the Nevada provider shortage.

Nurse Call Centers

Several nurse call centers are operated in Nevada and are available 24 hours a day, seven days a week.[cl] Because of the extreme distances many residents have to travel to access health care, nurse call centers provide access to health information and are a valuable resource to Nevadans. Typically, nurse call centers receive telephone calls from individuals requiring information, triage or immediate assistance. Trained nurses answer questions about medical symptoms and recommend actions to callers, such as physician referrals or directing callers to the appropriate level of care.[cli] REMSA's nurse call center is called a "Nurse Health Line" and is connected to the Washoe County 9-1-1 emergency telephone number and callers with non-emergent situations can receive referrals and/or transportation to locations other than an ED.

ED visits have been shown to decline by frequent users when they had access to nurse call centers. The Pew Charitable Trusts reported that in Washington, the state set up a 24-hour call center staffed by nurses to advise people about whether they were having a true medical emergency. In 2013, the first year of the call center's operation, ED visits by Medicaid enrollees declined by 9.9 percent, and resulted in $33.6 million in savings.[clii] The MPC can explore ways that health plans and other nurse call center operators can increase public awareness and use of this effective initiative to improve access to health information, and potentially experience cost savings through reduced use of EDs.

Community Health Workers

To mitigate provider access issues and assist individuals with navigating the health care delivery system, Nevada has introduced a pilot program that funded community coalitions to hire and deploy CHWs. The CHW pilot focused on chronic disease prevention and management of conditions including diabetes, heart disease, obesity and cancer. CHWs within the pilot program worked on prevention of chronic diseases by addressing clinical and nonclinical risk factors, which greatly influenced a person's risk profile and affects the management of their chronic disease state. Such factors include, but are not limited to, avoiding tobacco use, being physically active and having proper nutrition. The CHWs also help to increase access to health care for underserved Nevadans, by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. Additionally, the CHWs focus on addressing management of diseases by promoting chronic disease self-management programs, medication adherence and clinical monitoring.

The BLS anticipated 25.1 percent growth of the CHW role in the United States in the 10-year period from 2012 through 2022. In order to accommodate the increasing need, TMCC

and CSN continue to develop their CHW curriculum with plans to roll out an expanded online curriculum that would bring certified CHWs to rural areas, increasing the number of CHWs in these areas of the state.

Nevada will evaluate the sufficiency of the CHW training programs described in *Section VI*. The number of CHWs being certified and the geographic distribution of CHWs also will be evaluated. Nevada will utilize the PHIC and its committees to develop strategies to promote and ensure appropriate access to CHWs statewide.

Telemedicine/Telehealth

In 2011, the Nevada Legislature defined telemedicine and established its practice in the state. In 2015, Nevada passed legislation making it easier to practice telehealth in Nevada. The passage of AB292 amended Chapter 629 of NRS to further clarify the definition of telehealth and requires private insurance and Medicaid to pay for telehealth services.

Largely championed by the UNSOM, telehealth services have expanded to include behavioral health for online counseling and therapy, ophthalmology, radiology and many other subspecialties.

There are approximately 83 telemedicine sites in the state currently able to participate in direct consultations. Noteworthy is the fact that providers performing telemedicine services for patients who are presented to the remote site from Nevada must be licensed in Nevada.

Medical Licensing Compact

Nevada approved the Interstate Medical Licensing Compact (Title 54 of NRS amended by SB251), allowing for reciprocity of physicians from other states using an expedited license process for eligible physicians. As Nevada has too few licensed health care providers, this will be an asset to access care by providing more licensed physicians.

Project ECHO

Another innovative, successful project operated by the UNSOM is Project ECHO. The goal of Project ECHO Nevada is to offer an alternative to costly travel and long waits for patients in rural and frontier areas who need specialty care by supplementing the services of PCPs. By expanding the knowledge base of PCPs, patients in rural and underserved areas benefit from specialty care becoming available locally and without the cost and time of accessing specialists directly.

Behavioral Health Providers

Stakeholders were clear regarding the need for more behavioral health providers in the state of Nevada. To address the number of behavioral health providers, the state will explore the administrative simplification of the licensure reciprocation for behavioral health providers similar to the efficiencies achieved through participation in the Interstate Medical Licensure Compact. The state also will explore loan forgiveness programs that may exist or could be created to establish a pipeline of additional behavioral health providers and their practice in areas with high needs.

Increasing Physician Supply

Medical Schools in Nevada

The University of Nevada, Reno (UNR) is the only public medical school in the state, but there are recent expansions and partnerships that are in place at the University to increase the number of physicians in the state. The School of Medicine recently received its full requested appropriation from the 2015 Nevada Legislature of $5.5 million over the next two years, which will support the development and funding of a number of efforts to increase the supply of physicians in Nevada. These include:

- UNSOM collaborated with Renown Health in Reno (2014) and has committed to support the clinical teachings of third- and fourth-year medical students
- UNSOM has partnered with MountainView Hospital in Las Vegas. The program will expand GME slots from the current 233 positions in southern Nevada to 380 or more, including several medical specialties not currently available in the state beginning as early as July 2016.
- UNLV School of Medicine will have an inaugural class of 60 students starting in the fall of 2017
- Expansion of the Reno campus to a full four-year capability, which increases the number of residency positions available
- Funding of $200,000 in loan repayment programs
- Clinical teaching by community physicians (Community faculty members are educators, trainers, coaches and mentors who assist in improving the overall health care of Nevada)

Additional partnerships planned include local and regional hospitals, the Veteran's Administration, Cleveland Clinic, Nevada System of Higher Education Institutions and the DHHS. The state is collaborating with hospital partners to expand and develop new residency and fellowship training programs in specialties most needed in Nevada and most sought by medical students.

It is estimated that approximately 650 funded GME positions will be available after full implementation of the above programs.

If residencies do not increase in proportion with increasing numbers of medical school graduates, the projected physician shortage nationally cannot be adequately addressed. A compounding factor is that one-third of the current U.S. physician population is projected to retire within the next 10 years. It is estimated that Nevada's population of persons over 65 will double between 2015 and 2030, as the state's population is estimated to reach 3.7 million by 2030.

GME expansion along with undergraduate medical education (UME) are solutions for expanding the physician workforce. The UNLV School of Medicine will produce additional graduates who will matriculate into expanded publicly sponsored graduate training programs and become practicing physicians. Based on national averages, students who

complete both their UME and GME in Nevada have an 80 percent chance of remaining in the state. Students that only complete GME in Nevada have only a 60 percent chance of remaining in the state. Both UNSOM and the UNLV School of Medicine will work to add residency programs not currently available in Nevada.

The Primary Care Office (PCO) within the DBPH completes applications for federal designation of provider shortage areas, furnishes letters of support to qualified international applicants seeking a U.S. visa waiver to practice in underserved areas of Nevada and provides support for recruitment and retention of PCPs in designated areas.

Physician Retention

Loan Forgiveness

In an effort to help reduce the amount of debt physician's experience, the Nevada Health Service Corps (NHSC), established in 1989, offers loan repayment assistance to certain health care professionals who agree to practice in an underserved area of Nevada. Applicants must practice full-time, typically for a period of two years.[cliii] The list of health professionals includes:

- Doctors of Allopathic Medicine
- Doctors of Osteopathic Medicine
- General Practice Dentists
- Primary Care Certified Nurse Practitioners
- Certified Nurse-Midwives
- Primary Care Physician Assistants (PAs)
- Registered Clinical Dental Hygienists
- Clinical or Counseling Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Psychiatric Nurse Specialists (PNSs)
- Mental Health Counselors (MHCs)
- Licensed Professional Counselors (LPCs)
- Marriage and Family Therapists (MFTs)

Other Programs

Western Interstate Commission for Higher Education

WICHE is a 16-member commission working to boost access to higher education for students in the West and to ensure their success. Nevada has been a member of WICHE since 1959. Nevada's membership in WICHE allows students from Nevada to attend schools out of state at reduced tuition rates.

In 2014-15, 1,437 students from Nevada were enrolled in out-of-state programs at reduced rates. Additionally, Nevada received 4,202 students through WICHE's Western Undergraduate Exchange.

Nevada has sent 1,453 students to professional programs through the Professional Student Exchange Program (PSEP), with 43 students currently studying in a host of critical fields, including optometry, pharmacy, physician assistant and veterinary medicine. Nevada received 14 PSEP students from other states in 2014-15, along with $239,136 in support fees. Historically, some 89 percent of PSEP students return to Nevada to pursue their professional careers.

Physician Reciprocity

To support and facilitate the need for increasing physician supply, Nevada passed SB251, amending Title 54 of NRS, to become a member of the Interstate Medical Licensure Compact. The bill states that if a physician is licensed in Nevada, the Compact provides for reciprocal licensure for that physician in all other member states of the Compact. The Compact represents a national solution toward an expedited licensing process for eligible physicians and improves license portability and increases patients' access to care through the reciprocity process. To date, 11 states have passed legislation to become members of the Compact.

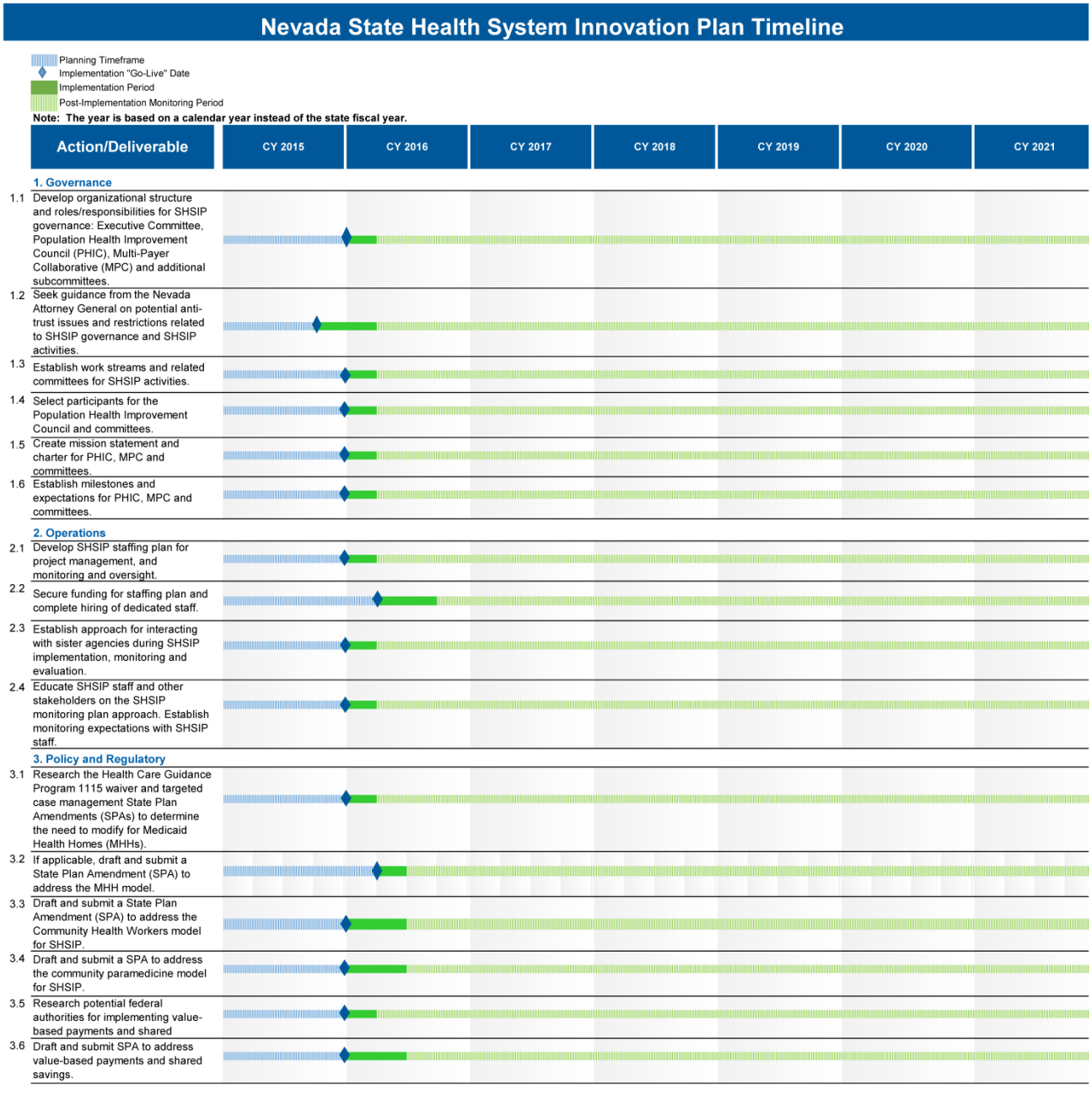
X. OPERATIONAL PLAN

A. Implementation Approach

The SHSIP implementation is based on a phased-in approach. As stated earlier, the implementation schedule will be dependent upon the availability of financial and human capital resources. In addition, the Nevada Legislature is on a biennial cycle and meets next in 2017. This time frame could impact specific SHSIP initiatives requiring legislative support.

The implementation time frames in the SHSIP operational plan are approximations. These approximations will be refined over time as implementation progresses. *Figure 34* shows the Nevada SHSIP implementation plan and timeline.

Figure 34: SHSIP Implementation Plan



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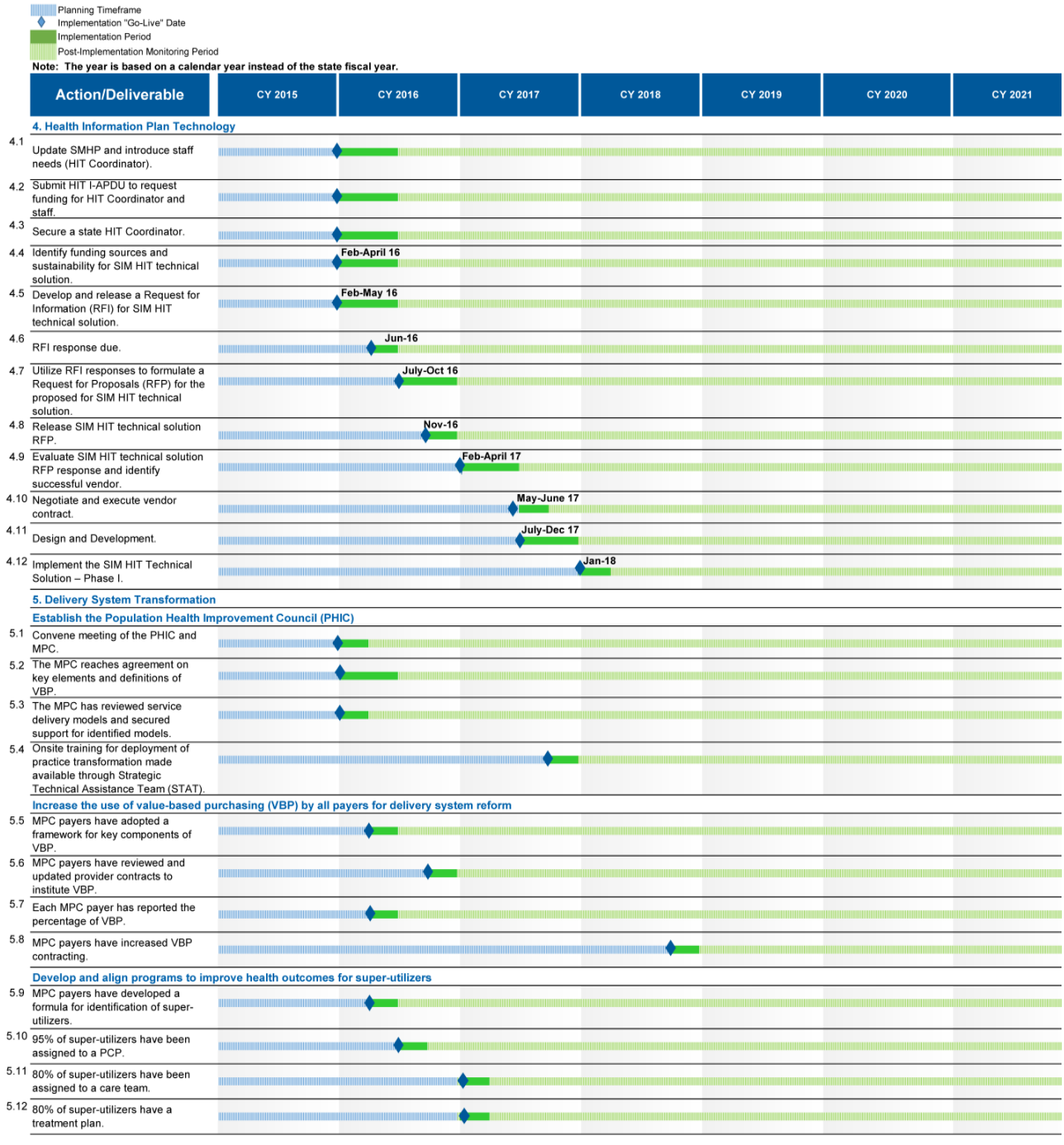
Nevada State Health System Innovation Plan Timeline



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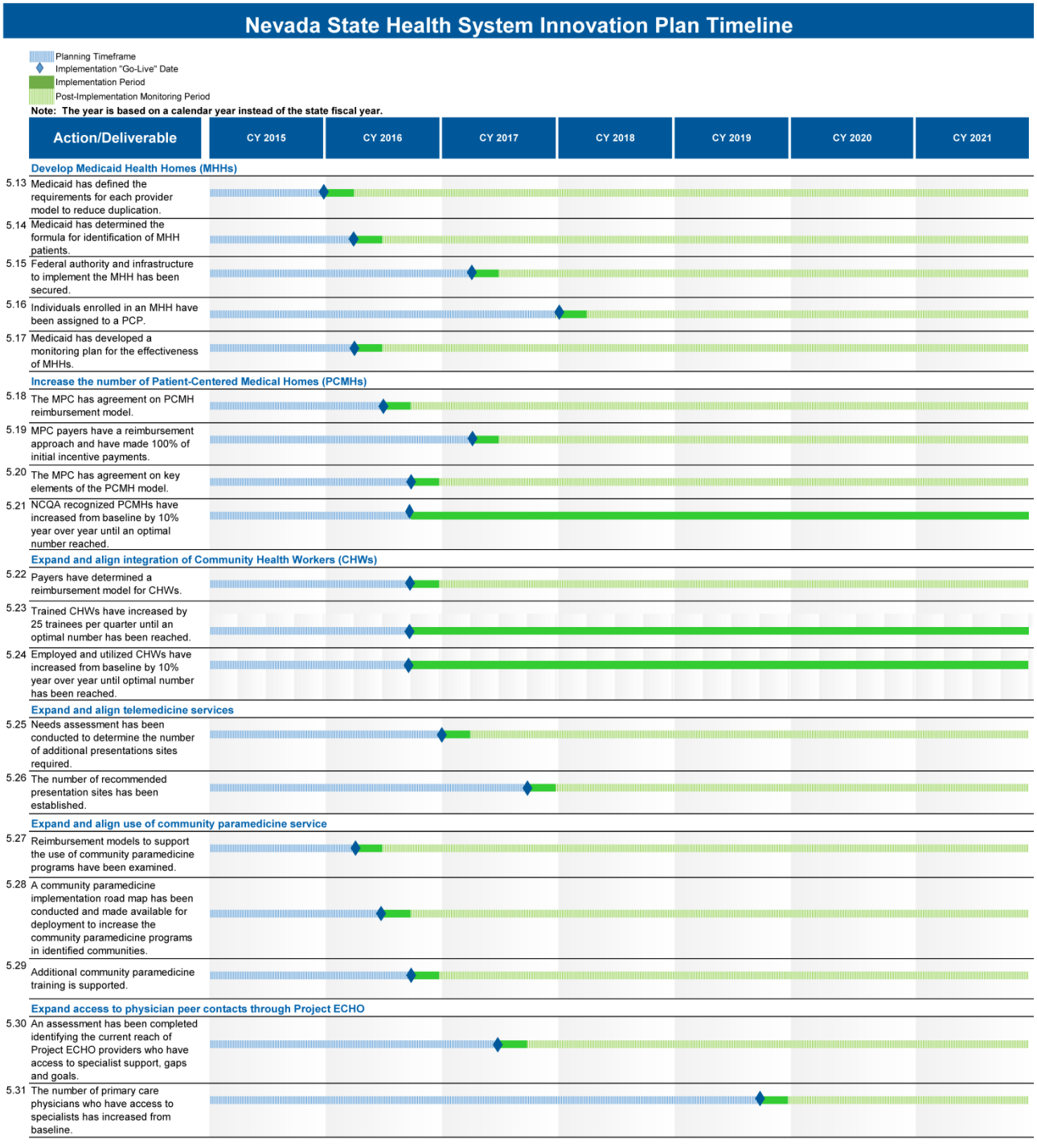
Nevada State Health System Innovation Plan Timeline



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Nevada State Health System Innovation Plan Timeline

Planning Timeframe
Implementation "Go-Live" Date
Implementation Period
Post-Implementation Monitoring Period

Note: The year is based on a calendar year instead of the state fiscal year.

	Action/Deliverable	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
	Support providers routinely practicing at the highest levels of their scope of practice to improve access							
5.32	Training and education to support scope of practice has been developed.							
5.33	Reimbursement policies that support appropriate use of practice levels have been reviewed, gaps identified and goals set.							
5.34	The utilization of physician extenders has increased from baseline.							
	Promote Health Care Workforce Development							
5.35	Medicaid has reviewed opportunities for GME, identified gaps and set new goals.							
5.36	The state has reviewed loan forgiveness programs, identified gaps and set new goals.							
5.37	The number of practicing physicians in targeted health professional shortage areas has increased over baseline.							
	Support and align tobacco cessation programs							
5.38	Marketing has increased from baseline.							
5.39	Education awareness of risks involved with e-cigarette usage has been evaluated.							
5.40	Methods to reduce administrative barriers to accessing tobacco cessation services have been identified and prioritized.							
	Support and align behavioral health care for persons with Serious and Persistent Mental Illness (SPMI)							
5.41	SAMHSA initiatives have been reviewed and prioritized to support the integration of physical health and behavioral health.							
5.42	Gaps to Certified Community Behavioral Health Clinic initiative have been identified and prioritized for supporting improvement.							
5.43	Peer support specialists are routinely utilizing supportive technology to maintain patient engagement.							
5.44	Gaps to the current Public Health suicide prevention initiative have been identified and prioritized for supporting improvement.							
5.45	Gaps to the National Governors Association's Medicaid Transformation Project have been identified and prioritized for supporting improvement.							
	Support and align obesity programs							
5.46	Gaps to Children's Heart Center pediatric obesity program have been identified and prioritized for supporting improvement.							
5.47	Gaps to the Medical Incentives for Prevention of Chronic Diseases grant have been identified and prioritized for supporting improvement.							
5.48	Gaps to current Public Health obesity initiative have been identified and prioritized for supporting improvement.							

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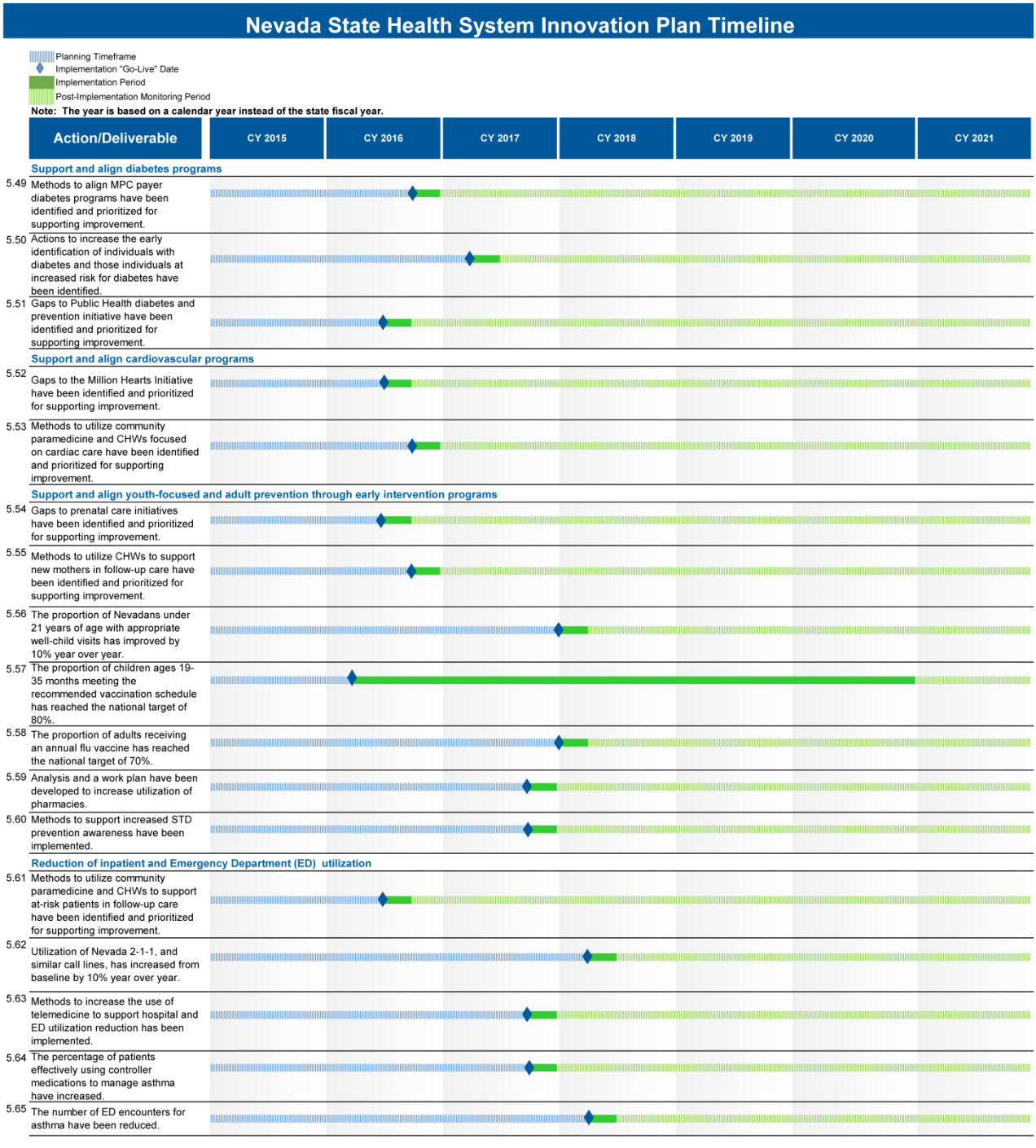
Nevada State Health System Innovation Plan Timeline



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Nevada State Health System Innovation Plan Timeline

Planning Timeframe
Implementation "Go-Live" Date
Implementation Period
Post-Implementation Monitoring Period

Note: The year is based on a calendar year instead of the state fiscal year.

	Action/Deliverable	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
	Support improved patient experience							
5.66	The number of surveys conducted to monitor key quality areas, as recommended by the MPC, have increased.							
5.67	The patient satisfaction score has increased year over year.							
5.68	Options to incentivize increased response rates for health surveys have been reviewed and prioritized.							
	Promote statewide Health Information Exchange (HIE)							
5.69	The HIE collaborative and structure is in place.							
5.70	The plan to expand HIE connectivity has been developed.							
5.71	Statewide direct messaging and notification system capability through HIE are operational.							
5.72	The number of providers connected to statewide HIE have increased to no less than 65% of the total provider community.							
	Develop population health management and analytics tool							
5.73	A plan for implementing a population health tool for tracking population health metrics has been developed.							
5.74	A population health tool to be used for value-based purchasing has been implemented.							
5.75	A single provider portal that allows for accessing provider-specific metrics and patient information has been developed.							
	Increase provider HIT technical assistance							
5.76	A plan for implementation of a population health toolkit to support meaningful use has been developed.							
	Utilize HIT to increase patient engagement, health literacy and joint decision-making							
5.77	A plan for implementation of a public portal for tracking and reporting quality metrics has been developed.							
5.78	Public portal for tracking and reporting quality metrics has been implemented.							
5.79	A plan for implementation of a public portal for offering health empowerment content has been developed.							
5.80	A public portal for offering health empowerment content has been implemented.							
	Develop an All Payer Claims Data Repository (APCDR)							
5.81	A plan for implementation of APCDR has been developed.							
5.82	APCDR has been implemented.							
	6. Monitoring and Evaluation							
6.1	Draft SHSIP monitoring plan to report on key program indicators.							
6.2	Develop approach for reporting results to SHSIP governance and other stakeholders.							
6.3	Implement SHSIP monitoring plan.							
6.4	Develop summative evaluation plan designed to provide independent analysis.							
6.5	Hire an independent contractor to implement the evaluation plan and report on performance and outcomes.							

B. Financial and Sustainability Plan

Fiscal Sustainability

Nevada is aware that at this point, CMMI does not anticipate a third round of SIM Model Test funds to be allocated to additional states. As such, Nevada must develop a sustainability plan that is built on incremental implementation of components of the health care delivery system and payment reforms that serve as the springboard for moving the plan forward and rolling out subsequent components of the plan. However, this environment creates a situation where no part of the plan can be implemented without an initial investment.

The initial investment in the SHSIP's implementation must come from one or more of the following sources: state funds allocation by the Nevada Legislature, pooled funds from participating payers or private grant funds. Given that the Nevada Legislature is on a biennial cycle that meets next in 2017 and that Nevada is like most other states with state budget shortfalls and fiscal constraints, the allocation of significant state funds may be highly unlikely without a strong business case and public support. The pooling of resources or forward movement on the plan by payers may serve as the initial stimulus as well. However, Medicaid and CHIP are two large payers behind the SHSIP, and both of them depend on state funds allocated by the legislature to make an initial investment. The third potential source of initial funding is to pursue private grant opportunities for the seed investment.

Nevada will pursue all three funding options for initial investment in its transformation efforts as well as any other source that may present itself. In addition to the initial investment sources, Nevada also will leverage existing programs and resources to contribute to sustainability. Using conservative savings and cost avoidance experienced by other payers implementing similar delivery system and payment transformation components, the Nevada DHHS will create a Medicaid and CHIP legislative funding request demonstrating the potential ROI. Investments from the other participating payers also will be sought to move forward with implementing similar features under their programs to ensure that multi-payer alignment is achieved.

Discussions regarding ROI also must include the expected "pay-back period" in which that return is expected to be realized. Naturally, investments in delivery system reform will precede any return, and the return may not be in the same budgeting cycle as the investment. Implementation of the Nevada SHSIP requires a long-term commitment and perspective. For example, investment in PCMHs under the SHSIP calls for investments in infrastructure and reporting prior to payment for outcomes. While early outcomes may result in savings from PCMH implementation, the full benefit of PCMH savings may not be realized for several years.

Engaging the more than 700,000 Nevadans receiving health care coverage by the Nevada payers committed to partnering for the transformation effort is a key requirement for success of the plan. These 700,000 lives covered by Medicaid, CHIP, IHS, PEBP and the CHF provide the opportunity to impact one out of every four Nevadans. The positive

outcomes, provider support, growing payer interest and patient engagement will help to drive the continued growth of the program.

Nevada Medicaid and CHIP are by far the largest programs under the design with more than 500,000 beneficiaries and over $2 billion in total cost per year. The next largest group is the CHF, which covers approximately 120,000 individuals in Clark County. Since the CHF is a private enterprise, the total cost and PMPM cost for the CHF is not available. The other large group is the Nevada PEBP, with more than 41,000 members and a total cost of care that exceeds $110 million per year.

Based on the available data, PMPM cost estimates range from $630 per month for PEBP employees, $374 per month for Medicaid and $143 per month for CHIP. It is estimated that including the 120,000 CHF members, the total cost of the five plans would be in excess of $2.1 billion a year.

At this point estimating a total, which will be achieved largely through cost avoidance, is very difficult. Methodologies to calculate savings must account for other confounding factors including, but not limited to, benefit design, intervention strategies, reimbursement, enrollment and utilization. If the implemented model resulted in savings or cost avoidance of only 1 percent, that would equate to approximately $21.8 million in savings or cost avoided per year. *Figure 35* shows a breakdown of major statistics and potential savings per program at 1 percent and 2 percent estimates for Nevada.

Figure 35: Nevada Estimated Savings/Cost Avoidance

	SFY 2014 CHIP	SFY 2014 Medicaid	SFY 2014 IHS	PEBP	CHF	Total
Populations Being Initially Considered						
Population	21,488	520,836	4,793	33,664	120,000	700,781
Total Cost	$37,963,456	$2,020,479,449	$13,406,760	$110,800,000	N/A	$2,152,649,715
PMPM	$143	$374	$233	$630	N/A	$1,380
Anticipated Cost Savings						
2%	$759,269	$40,409,589	$268,135	$2,216,000	N/A	$43,652,993
1%	$379,634	$20,204,794	$134,067	$1,108,000	N/A	$21,826,495

In formulating reasonable business cases to make funding requests, the experience and focus of other programs will be considered. In-state pilots and experience will be used first as proxies for potential investment and savings projections. Where in-state programs or experience do not exist, Nevada will utilize other states' or payers' experiences that are conservative and considered to be the most reasonable estimate of the Nevada experience

with a similar program. The similarity of population, access, focus of delivery system and payment design, infrastructure, etc., will all be considered in estimating savings or costs avoided as well as the potential pay-back period. *Figure 36* illustrates the type of review and information that will be utilized in this review process and the creation of Nevada-specific investment and ROI projections.

Figure 36: Return on Investment Projections

Program Type	Program Name	Description	Fiscal Results
Community Paramedicine			
	REMSA	Pilot community paramedicine program funded through Health Care Innovation Award. The program supports a triage call center, provides diversion to most appropriate source of care; performs medication reconciliation, medical plan adherence, point of care lab testing and health literacy promotion; and has specialized protocols for congestive heart failure, chronic obstructive pulmonary disease, myocardial infarction and cardiac surgery.	• Estimated $7.2M in avoided charges over a 2.5-year period.
	Humboldt General Hospital Community Paramedicine	Utilizes community paramedics to help rural residents' health and wellness through immunizations, health education, in-home risk assessments and preventive screenings. The community paramedics also provide in-home care under a physician's orders and follow-up after certain hospital discharges.	• Reduced hospital readmissions. • Reductions in hospital spending.
	Northern Dakota Western Eagle County Ambulance District	• Provides primary care services within their scope of practice, in a patient's home and under a physician's order. • Provides community based services in partnership with local public health and human service agencies.	• Average savings of $386 per avoided visit. • Average cost per visit of $119.17.[cliv]
	MedStar EMS Community Health Program	Fort Worth, Texas, community paramedicine program focused on reducing acute emergency medical care needs and costs.	• Estimated over $16,000 per patient enrolled over a 12-month period. • 47% decrease in hospital admissions among enrolled patients. • Congestive heart failure at-risk focused interventions save an estimated $39,000 per patient enrolled.[clv]

Program Type	Program Name	Description	Fiscal Results
Physical Health and Behavioral Health Integration			
	Intermountain Healthcare (Utah) Mental Health Integration (MHI) Program[clvi,clvii]	• A comprehensive, team-based mental health approach available to all patients. • PCPs and their staff are integrated with mental health professionals, community resources, care management, the patient and his/her family. • Patients complete a comprehensive assessment tool; an algorithm then stratifies patients into categories. Available resources are matched to the patient's need. • As of 2010, implemented in 69 of Intermountain's 130 primary care clinics. • Quasi-experimental, retrospective cohort study measured MHI's impact on cost and quality.	• MHI patients in the 12 months after initial diagnosis of depression were 54% less likely to have an ED visit and had fewer claims for total primary care and psychiatry. • The rate of growth in treatment costs between the 12-month pre-mental health diagnosis period and the 12-month post-diagnosis period was $405 less for MHI patients than for the usual care cohort ($640 for MHI, compared with $1,045 for usual care).
	Colorado Access Integration Model[clviii]	• Colorado Access is a non-profit managed care plan with contracts as a regional Medicaid HMO and mental health carve-out. • Care coordination model in which care managers who are registered nurses in the MCO work with medical and behavioral health providers to coordinate care and develop a care plan. Care managers also provide outreach and treatment support calls to patients. • Centralized care management in the plan with telephonic or onsite contact based on risk stratification.	• Patients in the program had fewer office visits, ED visits, hospital admissions and hospital days. • Overall savings of $170 PMPM ($2,040/year), and an overall decrease in health spending for high-risk/high-cost patients of 12.9%.
	Aetna's Depression in Primary Care Program[clix,clx]	• Aetna reimburses PCPs for administering a Patient Health Questionnaire, or PHQ-9, to patients, and providing follow-up consultations for patients who are put on antidepressants or referred to psychiatrists or psychologists.	• A decrease in medical costs of $175-$222 PMPM (most of this in inpatient care) and an increase in pharmacy costs of $21-$40. PMPM ($8-$11 in antidepressants). The net savings was about $136-$201 PMPM. • However, these figures were limited to a small subset of Aetna enrollees who had very high risk of medical care and were already in an active case management program; they also had higher risks of depression.

Program Type	Program Name	Description	Fiscal Results
Physical Health and Behavioral Health Integration (cont'd)			
	Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) Research Trials[clxi,clxii,clxiii,clxiv]	• Primary care based collaborative care model for late-life depression in 18 primary care clinics across the United States. • One year stepped collaborative care program: a nurse or a psychologist care manager works in the participant's primary care clinic to support the patient's PCP. • Collaborative approach to defining goals and developing a personalized treatment plan. Treatment plan includes patient preferences, proactive follow-up and outcomes monitoring by a depression care manager, targeted use of specialty consultation, and protocols for stepped care. • Randomized control trial of 1,801 depressed primary care patients 60 years or older measured long-term health care costs of patients in program.	• Over a four-year period, IMPACT patients had lower average net costs for their medical care ($3,363 less) than patients receiving usual care (total health care costs were $29,422 compared to $32,785 for usual care patients). • Intervention patients had lower health care costs in every cost category: outpatient and inpatient mental health, outpatient and inpatient medical and surgical, pharmacy and other outpatient costs. • Corresponds to an ROI of $6.50 per dollar spent. • At the Kaiser Permanente Southern California site, total health care costs decreased 14% per year during the IMPACT study and an additional 9% for one- year post study.
Patient-Centered Medical Homes			
	Highmark Patient-Centered Medical Home Program	PCMH program that began in 2011 and in 2013 included 1,050 primary care doctors with 171,000 members.	• 5% decrease in PMPM for patients with coronary artery disease. • 3.5% decrease in total PMPM for patients with diabetes. • 2 % decrease in overall health care costs.[clxv]
	CareFirst BlueCross BlueShield	Regional PCMH in Northern Virginia, the District of Columbia and Maryland. Program includes more than 4,000 PCPs who may earn incentive payments based on quality and savings.	Per 1,000 CareFirst Members: • 6.4% reduction in hospital admissions. • 11.1% fewer days in hospital. • 8.1% fewer readmissions. • 11.3% fewer outpatient health facility visits.[clxvi]
	Northeast Region of Pennsylvania Chronic Care Initiative	Began in 2009 and included two commercial plans and 27 primary care practices involving an estimated 17,363 patients.	• Lower all case hospitalization rate. • Lower ED visits. • Higher ambulatory primary care visits.[clxvii]

Program Type	Program Name	Description	Fiscal Results
Community Health Workers			
	Community Outreach and Cardiovascular Health (COACH) trial	Paired nurse practitioners and CHWs to manage cardiovascular disease.	• $157 reduction per patient in cost for every 1% drop in systolic blood pressure. • $190 reduction in cost for every 1% drop in diastolic blood pressure.[clxviii]
	Colorectal Cancer Male Navigation Program	A colonoscopy screening and navigation program designed for Hispanic men using CHWs.	• Health care savings of $1,148 per program participant.[clxix]
	Asthma Education and Management Program	Chicago-based pilot pairing African-American children with asthma with a CHW.	• Asthma symptom frequency was reduced by 35% among adolescents, resulting in a savings of $5.58 per dollar spent on the intervention.[clxx]

Operational Sustainability and Governance

The Nevada SHSIP is a multiyear plan that is expected to evolve and grow as more payers engage, funding sources are identified, and the needs of the population change. For the foreseeable future, the governance and fostering of the SHSIP implementation will fall under the Nevada DHHS. The project will be staffed to provide project management as well as project monitoring and evaluation support to the effort. These operational staff will support the PHIC and its subcommittees.

The MPC will serve as a subcommittee to the PHIC. Also reporting into the PHIC will be an Outcomes Subcommittee, Provider Subcommittee and other subcommittees that may become necessary to conduct the business of implementing the SHSIP. Such activities across the PHIC and its committees are expected to include: consensus on population health focus areas, outcome measures and methodologies to be used, targeted improvement goals, and provider payment models to meet Nevada's aims. The underlying principle behind the inclusion of the MPC is that true payer and provider buy-in requires a voice in the decision-making process.

Collectively, the PHIC will be supported by the MPC and subcommittees to conduct an array of activities. These activities may include:

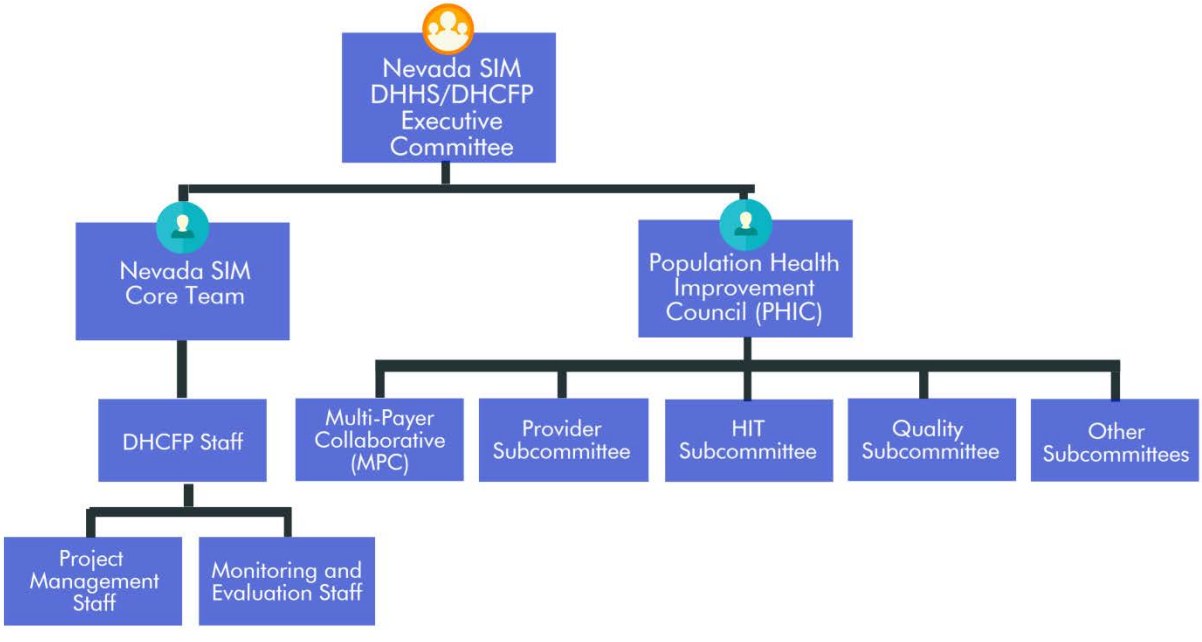
- Exploration of health outcome objectives
- Targeted population health improvement goals
- Unified messaging regarding expectations of providers and administrative simplification for participating providers
- Financial alignment to develop the common structure of the value-based reimbursement program

This PHIC will continuously look for opportunities to improve the existing models and ensure that provider, patient and other stakeholder concerns are evaluated and incorporated into the model as the delivery system and payment transformation efforts are deployed.

Equally important is to acknowledge the limitations on the scope of the PHIC responsibilities and authority. Nevada's stakeholders have recognized both the need for commonality across involved payers, and the reality that payer involvement will depend on their ability to maintain some degree of autonomy. Therefore, the MPC will strive toward commonality regarding statewide priorities, clinical practice guidelines, national metrics that will be used to evaluate outcomes, and key structural components of value-based reimbursement. However, payers will maintain some degree of flexibility in their business rules and processes to fine-tune plan-specific requirements.

The Nevada SIM Core Team will continue to serve as the point of responsibility for making operational and evaluating the SHSIP. This staff will support the PHIC and handle all logistics and business support for the PHIC. The SIM Core Team will serve as the liaison between the DHHS and the PHIC. The Nevada SIM Executive Committee will retain ultimate decision-making authority over the PHIC. *Figure 37* illustrates the Nevada SIM organizational chart.

Figure 37: Nevada SIM Organizational Chart



While the SHSIP implementation governance will be initiated by the Nevada DHHS, periodic evaluations will be performed to assess the appropriateness of this governance structure and recommend modifications based on performance, maturity of the model and degree of other payer involvement. The approach toward governance will need to be conservative but flexible to adjust to changing Nevada needs and environment.

Regulatory Levers for Sustainability

From a Medicaid and CHIP standpoint, sustainability also will require regulatory levers to be addressed. The DHHS will have to undergo a process to develop and negotiate a CMS-approvable State Plan Amendment (SPA). At a minimum, SPAs will be needed to develop and implement the MHH model, PCMH program, reimbursement for CHWs and community paramedicine services, and the value-based reimbursement program. A review of Nevada's current 1115(a) waiver establishing the HCGP as well as the components of the State Plan related to TCM must be reviewed to ensure no duplication of services are produced as a result of the enhancements to the health care delivery system. Any necessary modifications to these extant programs may necessitate SPA or 1115 amendments to reflect the new environment.

C. Monitoring and Evaluation

Nevada will implement a monitoring and evaluation plan to evaluate the implementation of the SHSIP and rapidly identify if intended results are being accomplished. This information will be used to improve the efforts to maximize the outcomes accomplished. Nevada also will conduct comprehensive evaluations of longer term outcomes and accomplishments through externally performed independent evaluations. The first activity is an effective monitoring plan that routinely examines the progress of implementing the primary and secondary drivers and tracks achievement toward the four Nevada aims.

Monitoring should occur routinely, at a minimum quarterly, to report on key program indicators (KPIs) to the Executive Committee, PHIC and interested stakeholders and be made publicly available.

The monitoring plan should be the responsibility of capable staff charged with accurately monitoring completed drivers. The monitoring plan also should capture challenges that engaged parties are experiencing in implementing the aforementioned actions. This reporting should allow for actionable course correction to overcome noted barriers and continue to push Nevada forward.

The second activity is a final summary evaluation plan that should be designed to provide an independent analysis of how well the aims were met. Qualitative and quantitative methodologies would be expected. Nevada will hire an independent contractor to develop, initiate and report on whether the aims were met. Root cause analysis on changed provider behavior, improved patient experience and clinical outcomes in particular should be addressed.

XI. CONCLUDING COMMENTS

Nevada has conducted a diligent process to develop a road map to transform the delivery and payment systems in the state. This process involved strong input and engagement from a wide array of stakeholders. Through the stakeholder engagement process and research of the existing health care delivery and payment systems, numerous opportunities for improvement have been identified and solutions presented in the SHSIP. These solutions call for substantial changes from the current environment and require continued stakeholder involvement and collaboration.

Throughout the SHSIP, most of the transformation efforts rely on the effective adoption, implementation and use of HIT and infrastructure. The movement to VBP holds providers to a new level of accountability for outcomes and requires better information at the point of care, the ability to share health information and measure outcomes. These components are true not only at the individual provider level but at the aggregate population level as well. Payers will need the ability to measure the population health for patients attributed to a provider to determine eligibility for VBPs. Additionally, the state will need to have the ability to measure population health and health improvement at a statewide level. Each of these components requires a strong HIT/HIE infrastructure.

Emphasized in the SHSIP is the PHIC. The PHIC and its committees will bring together resources from a broad cross section of Nevada's stakeholders to work collaboratively toward transformation. Leveraging the experience, expertise and resources of the participants of this group will help drive transformation in a unified manner. Many areas of the SHSIP rely on the advice and direction of the PHIC and its committees. Providers, payers, citizens and other stakeholders must be part of the detailed decisions that drive how the SHSIP road map is executed.

While opportunities and solutions have been identified, implementation of the transformation effort will require a dedicated and persistent focus. The transformation elements described in this document have multiple levels of detail that will have to be determined as implementation moves forward. These details will include, but may not be limited to, provider buy-in, multi-payer commitment, CMS approval, competing priorities and funding. Dedicated and creative individuals whose mission is to move the implementation of the SHSIP forward must be identified and empowered to ensure progress.

The SHSIP is a dynamic document that will require constant attention and adjustment. The health care environment is ever changing. The priorities, activities and timelines will need to be constantly evaluated and modified as necessary. However, the ultimate goal of achieving the triple aim of healthier people, better care and smarter spending for Nevadans should always remain central to these efforts.

XII. ATTACHMENT A: REFERENCE GUIDE

The first section of this reference guide identifies current programs and grants that the Nevada SHSIP seeks to leverage and enhance.

The second section of this reference guide provides a broader overview of all current federal grants to the state, with potential relevance to the implementation of SHSIP. During SHSIP implementation, stakeholders may identify ways to leverage these grants.

Current Programs to Leverage through SHSIP Implementation

Certified Community Behavioral Health Clinics (CCBHC) Program

Nevada received a planning award from SAMHSA to increase the integration of physical health and behavioral health treatment. Certified clinics are responsible for care coordination, which involves organizing care activities among different services and providers, and across various facilities. Goals for this program include improving the availability of, access to and participation in assisted outpatient mental health treatment, and demonstrate the potential to expand available behavioral health services without increasing net federal spending. The SHSIP will support efforts to ensure these goals are met.

Balancing Incentive Payment (BIP) Program

This federal funding helps increase diversions from nursing homes to long-term services and supports. Nevada will leverage the centralized resources and accessibility of those resources through the Nevada 2-1-1 system funded through the BIP program. The Nevada 2-1-1 system will help connect individuals with resources and assist them in navigating the health care system.

Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD)

This expired grant program educated, supported and incentivized patients to modify behavior and achieve targeted health improvement goals. Notably, weight management programs for pediatric patients were provided through the Children's Heart Center. This experience will be leveraged and elements considered for replication as appropriate.

Project ECHO

In order to expand access to specialist physicians, the current reach of Project ECHO will be assessed and expanded. The service provides simple telehealth linkage of specialists to PCPs in rural and underserved areas, thereby extending specialty care to patients with chronic, costly and complex medical illnesses.

Nevada Broadband Telemedicine Initiative (NBTI)

The Nevada Hospital Association (NHA) manages the initiative originally funded with $19.6 million under the federal Broadband Technology Opportunities Program and supplemented with private matching funds. A vendor operates the NBTI network, which seeks to expand telehealth efforts and increase the exchange of EHR.

Million Hearts Initiative

Nevada is an active participant in the Million Hearts campaign, which seeks to prevent heart attack and stroke, in partnership with health providers and broad public health initiatives. Heart disease and stroke are a major cause of mortality and morbidity in Nevada. This campaign will be leveraged to help improve Nevada's outcomes in this area, in part by using key clinical measures to assess provider performance.

Nevada Tobacco Quitline

The Quitline offers counseling and nicotine replacement for individuals seeking to quit smoking. This resource is available to all Nevadans free of charge. The PHIC, and more specifically the MPC, will explore opportunities to utilize the Quitline in their care plans and find avenues to support the Quitline. Public awareness of this resource through community-level interventions and efforts will be explored by the PHIC.

Heart and Stroke Prevention and Control Program

This DPBH program seeks to prevent and reduce premature death and disability from heart disease and stroke among Nevadans through: prevention, detection and treatment of heart disease and stroke risk factors; prompt and early detection and treatment of heart disease and stroke; and elimination of disparities in heart disease and stroke care. These activities are aligned with the national Million Hearts initiative to prevent 1 million heart attacks and strokes in five years. Utilizing the community engagement and awareness activities initiated by this group, education and awareness regarding cardiovascular disease prevention, treatment and early identification of an event will be leveraged through the PHIC. The PHIC will promote common messaging and clinical practice guidelines.

Obesity Prevention and Control Program

This program connects Nevadans with strategies to address healthy body weight and obesity prevention. Community awareness of the services offered through this program will be promoted through the implementation of the plan. The PHIC will be educated on the available resources through this program, and the PHIC and MPC will work to leverage these resources across payers. Providers also will receive education regarding the program and its availability as a resource for them and their patients.

Diabetes Prevention and Control

The PHIC will leverage the DPBH Diabetes Prevention and Control Program, which seeks to reduce disease, disability and death related to pre-diabetes and diabetes. The resources available through this unit will be leveraged in plan to: strengthen professional and public education for diabetes prevention and control, foster diabetes prevention education and diabetes self-management education, and increase the links between community and clinical resources to support prevention, self-management and control of diabetes, and garner improved outcomes. These resources address diabetes at the state, regional and local levels and will be leveraged and supported in implementing the SHSIP.

Existing Medicaid 1115 Waivers and State Plan Amendments

These existing Medicaid programs will need to be researched to assure non-duplication and, as feasible, to modify for alignment with the MHH model. Any necessary modifications

to these extant programs may necessitate SPAs or 1115 amendments to reflect the new environment. As part of the payment transformation and alignment process, a review of these key Medicaid contracts will be conducted. This review will focus on opportunities to align the state's transformation priorities and focus areas with these key contracts. The Managed Care Organization and Health Care Guidance Program contracts offer powerful levers to produce the results desired by Nevada. Aligning these contracts with the desired results and introducing a value-based contracting approach stands to offer the financial incentive to the vendors to reach those common objectives.

Health Care Guidance Program—Approved Waiver

The Nevada Medicaid Health Care Guidance Program (HCGP) operates under an 1115(a) waiver providing support to certain patients with chronic conditions. A multidisciplinary team addresses the needs of individuals with complex, chronic conditions. The Medicaid fee-for-service (FFS) population receives care management and coordination services through a third-party vendor. Incorporation of the MHH will have to be in a manner that reinforces the goals of the PCMH and health home models without duplicating the HCGP efforts.

Managed Care Organizations (MCOs) in Washoe and Clark Counties—State Plan Amendments

The Medicaid population residing in Washoe and Clark counties is currently included in the state's Medicaid MCO effort. The Nevada MCO vendors provide care coordination and care management services. Final design elements that are separate but complementary to the MCO effort must be distinguished and recorded.

Behavioral Health in Youth Transformation —Pending Waiver

Nevada has submitted a section 1115 waiver application for youth behavioral health. Nevada seeks further integration of behavioral and physical health care services for youth. SHSIP will leverage the National Governors' Association Medicaid Transformation project in Nevada, which seeks to transform the behavioral health system for youth (ages 11 to 18 years) from a crisis-based service system to a system of prevention and early intervention.

Compendium of Current Grants with Potential Relevance to SHSIP

This section provides a list of Nevada's federal grants identified as potentially relevant to accomplishing the SHSIP goals. The identified awards in Figures 38, 39 and 40 may or may not be leveraged for creating structural changes in health care delivery and payment systems. Nonetheless, the implementation of the grants should independently contribute to the priority population health outcomes measured by SHSIP. During SHSIP implementation, stakeholders may identify ways to leverage additional existing grants, in order to create sustainable changes to health care delivery and payment systems.

Figure 38: Behavioral Health Grants to SHSIP

Area	Grant Title	Grantor Agency	End Date
Behavioral Health	Planning Grant for Certified Community Behavioral Health Clinics	SAMHSA	10/2016
	Nevada Safe Schools/Healthy Students	SAMHSA~CMHS	9/29/2017
	Block Grants for Community Mental Health Services	SAMHSA~CMHS	9/30/2016
	Cooperative Agreements to Benefit Homeless Individuals for States—Nevada Supplement	SAMHSA	9/29/2016
	SPF PFS (Partnership for Success)—Underage Drinking and Rx Drug Abuse, ages 12-25.	SAMHSA	9/29/2018
	Statewide Co-op to Improve Youth Treatment	SAMHSA	9/29/2017

Figure 39: Chronic Disease Grants Relevant to SHSIP

Area	Grant Title	Grantor Agency	End Date
Tobacco	Tobacco Control Program	CDC	3/28/2020
	PPHF 2014 Tobacco Use Prevention and Public Health Approaches for Ensuring Quitline Capacity	CDC	7/31/2018
Diabetes/Heart Disease/Obesity	State Public Health Actions to Prevent and Control Diabetes, Heart Disease and Obesity	CDC	6/29/2018

Figure 40: Other Grants Relevant to SHSIP

Area	Grant Title	Grantor Agency	End Date
Workforce Development	State Primary Care Offices	HRSA	3/31/2019
HIE	Health Information Exchange	ONC (Office of the National Coordinator for HIE)	9/10/2016
Vaccines	Nevada Immunization and Vaccines for Children	CDC	12/31/2017
	Nevada Billing Implementation Project	CDC	9/29/2016
Cancer Screenings	Funding and Project Proposal for Cancer Prevention and Control Programs in Nevada (NBCCEDP)—Breast and Cervical Cancer	CDC	6/29/2017
	Organized Approach to Increase Colorectal Screening	CDC	6/29/2020
Antenatal Care	Nevada Maternal and Child Health State Systems Development Initiative	HRSA	11/30/2017
STIs	Nevada STD Prevention and Control Program	CDC	12/31/2018
HIV	PS12-1201 Comprehensive HIV Prevention Project for Health Departments	CDC	12/31/2016
Population Health Surveillance	Nevada's Youth Risk Behavioral Surveillance Survey	CDC	7/31/2018
	Surveillance Program Announcement: Behavioral Risk Factor Surveillance System	CDC	3/28/2020
	Office of Public Health Informatics and Epi proposes to utilize HIV/AIDS Case Surveillance	CDC	12/31/2017
	National Syndromic Surveillance	CDC	8/31/2019

XIII. ATTACHMENT B: GLOSSARY

TERM	DEFINITION
AAMC	*Association of American Medical Colleges*: A nonprofit organization that administers the Medical College Admission Test and that operates the standardized electronic applications for medical schools and residency programs.
ACO	*Accountable Care Organization*: An organization of health care providers providing care to Medicare beneficiaries enrolled in traditional FFS programs, where reimbursement depends in part upon the quality of care and the control of costs.
ADA	*Americans with Disabilities Act*: Federal law prohibiting discrimination based on disability.
ADSD	*Aging and Disability Services Division*: Operates under the Nevada DHHS and provides senior programs, disability programs and early intervention services for children.
ADT	*Admission/Discharge/Transfer*: A health information system holding patient data and allowing appropriate sharing.
ALF	*Assisted Living Facility:* A residential facility for groups that provides food, shelter, assistance and limited supervision.
AOD	*Alcohol and Other Drug (AOD) Dependence*: Substance use characterized by involuntary dependence.
APCDR	*All Payers Claim Data Repository*: Systematically collects claims data and provider information from public and private payers, allowing for analysis of the cost and quality of care.
APM	*Alternate Payment Models*: Introduce value-based reimbursement models focused on quality care, health outcomes and cost.
APN	*Advanced Practitioners of Nursing*: A certified level of nursing that was replaced by the licensing of APRNs.
APP	*Application*: Computer software program.
APRN	*Advanced Practice Registered Nurse*: A licensed level of practice for nurses, introduced in Nevada by legislation in 2013.
ARRA	*American Recovery and Reinvestment Act*: A national economic stimulus bill passed in 2009, which included the HITECH Act.
BH	*Behavioral Health*: Concerned with promoting mental health and improving health behaviors by understanding emotions, actions and biology.
BIP	*Balancing Incentive Payment*: The program provides states increased federal funding to increase diversions from nursing homes to long-term services and supports.
BLS	*Bureau of Labor Statistics*: Located within the U.S. Department of Labor.
BMI	*Body Mass Index*: A measure of body fat based on height and weight.
BRFSS	*Behavior Risk Factor Surveillance Survey*: An annual population survey conducted by states and funded by CDC.
CAAHEP	*Commission on Accreditation of Allied Health Education Programs*: A nonprofit organization that accredits postsecondary education programs in various allied health fields.
CAD	*Coronary Artery Disease*: The most common form of cardiovascular disease and characterized by hardened and narrowed coronary arteries.
CAHPS	*Consumer Assessment of Healthcare Providers and Systems*: Patient surveys that evaluate experiences and satisfaction with health care.
CCBHC	*Certified Community Behavioral Health Clinics*: Coordinate access to care and services across providers and facilities, under a prospective payment system.
CDC	*Centers for Disease Control and Prevention*: National public health agency under HHS.

TERM	DEFINITION
CHC	*Community Health Center*: A nonprofit organization that provides primary health services to residents of underserved areas.
CHCS	*Center for Health Care Strategies*: CMMI technical assistance vendor.
CHF	*Culinary Health Fund*: A Taft-Hartley labor management trust fund to help qualified employees purchase health insurance.
CHIA	*Center for Health Information Analysis for Nevada*: Research center, at University of Nevada Las Vegas, that collects financial and utilization data from hospital and ambulatory surgical centers.
CHIP	*The State Children's Health Insurance Program*: Offers free or low-cost health coverage for eligible children and family members and operates as a partnership between the federal and state governments.
CHW	*Community Health Workers*: Frontline public health workers, who understand the community and provide health education and connections to the health system.
CMMI	*Center for Medicare & Medicaid Innovation*: Established to test new payment and service delivery models that reduce cost and maintain or improve the quality of care.
CMO	*Care Management Organization*: Provide individual patients with coordinated and integrated access to providers of health and social services.
CMS	*Centers for Medicare & Medicaid Services*: Operates under the HHS and administers Medicare, Medicaid, CHIP and the federal HIX.
CNF	*Certified Nursing Facility*: Nursing facilities federally certified for Medicare and/or Medicaid.
COACH	*Community Outreach and Cardiovascular Health*: Trial demonstrating potential savings from community health workers paired with nurse practitioners for the management of cardiovascular disease.
CoAEMSP	*Committee on Accreditation of EMS Education Programs*: A nonprofit organization that accredits education programs for emergency medical services.
COPD	*Chronic Obstructive Pulmonary Disorder*: A group of progressive lung diseases that block airflow and make it difficult to breathe, for which the leading cause is cigarette smoking.
CPG	*Clinical Practice Guidelines*: Systematic guidance for practitioners to make decisions of appropriate health care under specific circumstances.
CRS	*Congressional Research Service*: Nonpartisan shared researchers of the U.S. Congress.
CSN	*College of Southern Nevada*: Offers a Community Health Worker training program.
DCFS	*Nevada Division of Child and Family Services*: Operates under DHHS and protects children from abuse and neglect by providing support and services to children and families.
DETR	*Nevada Department of Employment, Training and Rehabilitation*: Offers assistance in job training, vocational rehabilitation, workplace discrimination, and in collecting and analyzing workforce and economic data.
DHCFP	*Division of Healthcare Financing and Policy*: Coordinates with the Centers for Medicare & Medicaid Services to promote quality care and retain health costs, in purchases of health services for enrollees of Medicaid and Nevada Check Up.
DHHS	*Nevada Department of Health and Human Services*: Promotes the health and well-being of residents and is the largest department in state government.
DPBH	*Division of Public and Behavioral Health*: Provides coordination of state programs promoting physical and behavioral health, under the Nevada Department of Health and Human Services.
DWSS	*Division of Welfare and Supportive Services*: Operates under the DHHS and provides services to families, the disabled and older adults.

TERM	DEFINITION
ECNS	*Emergency Communications Nurse System (ECNS) Protocol*: Comprised of more than 200 protocols and uses a series of medical questions to determine the appropriate level of care and to identify other appropriate community services.
eCQMs	*Electronic Clinical Quality Measures*: Standard measures for assessing quality, transmitted from an electronic health record under set electronic specifications.
ED	*Emergency Department*: Owned or operated by a hospital and subject to regulations addressing appropriate medical screening, medical stabilization and transfer of patients.
EHR	*Electronic Health Record*: A patient-specific medical record, capable of being sharing with providers across health care organizations.
EMS	*Emergency Medical Services*: Health services involving treatment and transport of people in crisis health situations.
EMT	*Emergency Medical Technician*: Certified providers of emergency medical services, with certification levels defining technical expertise and potential scope of work.
EPA	*Environmental Protection Agency*: Federal agency that writes and enforces environmental regulations passed by the U.S. Congress.
ERS	*Economic Research Service*: Operates within the U.S. Department of Agriculture and conducts economic analysis of various issues.
FAQ	*Frequently Asked Questions*: Common inquiries.
FDA	*Food and Drug Administration*: A federal agency within HHS, charged with promoting the safety of food and medications.
FFS	*Fee-for-Service*: Payment of health providers for each medical service.
FQHC	*Federally Qualified Health Center*: Community based organizations that provide comprehensive primary care and preventative services regardless of ability to pay.
GME	*Graduate Medical Education*: Formal education, including residencies and fellowships, pursued after obtaining the M.D. or DO degree.
HCGP	*Health Care Guidance Program*: Nevada Medicaid's research and demonstration project to provide individualized care for certain people with chronic conditions or high utilization.
HEDIS	*Health Effectiveness Data and Information Set*: A tool used by more than 90 percent of health plans to measure performance.
HHS	*United States Department of Health and Human Services*: A cabinet-level department of the federal government charged with protecting and promoting the health of Americans.
HIE	*Health Information Exchange*: A computerized system that allows for access and sharing of patient-specific health data across organizations and with patients.
HIT	*Health Information Technology*: The technology infrastructure allowing for secure and efficient exchange of health information.
HITECH Act	*Health Information Technology for Economic and Clinical Health Act*: Promoted adoption and meaningful use of HIT.
HIX	*Health Insurance Exchange*: Facilitates the purchase of health insurance through an online marketplace.
HL7	*Health Level Seven*: A set of standard structures for reporting clinical and administrative data between health care providers using software applications.
HPSA	*Health Professional Shortage Area*: Characterized by a lack of primary care physicians, dentists or dental assistants, and psychiatrists
IHS	*Indian Health Service*: Agency within HHS, providing health care to Native American and Alaskan Native peoples.
IMPACT	*Improving Mood: Promoting Access to Collaborative Treatment*: Research trials demonstrating lower health care costs from primary care-based collaborative care of patients with late-life depression.

TERM	DEFINITION
IPDU	*Implementation-Advanced Planning Document Updated*: Procedures to be implemented by the state for continued federal financial participation in the cost of acquiring information technology.
IRF	*Inpatient Rehabilitation Facility*: Provides intensive rehabilitation services and 24-hour medical and nursing management.
KPI	*Key Program Indicator*: Indicators for routine reporting to track achievement.
LTAC	*Long Term Acute Care Facility*: Provide intensive and long-term hospital care to severely ill and medically complex patients.
MCH	*Maternal and Child Health*: Concerns the health of children together with the health of women during pregnancy, birth and postpartum.
MCO	*Managed Care Organization*: Serves the majority of Medicaid enrollees nationwide and accepts per member per month capitated payments from the state instead of the state paying providers directly.
MHH	*Medicaid Health Home*: A State Plan Option to provide a coordinated system of comprehensive care to enrollees with chronic conditions.
MHI	*Mental Health Integration*: Comprehensive, team-based mental health provided to patients together with integrated primary care.
MIPCD	*Medicaid Incentives for Prevention of Chronic Diseases Grant:* See Reference Guide in *Attachment A.*
MPC	*Multi-Payer Collaborative*: Aligns funding from both commercial and public payers to incentivize providers.
MU	*Meaningful Use*: Use of EHRs to improve health care and preserve privacy. The Medicare and Medicaid EHR Incentive Program provides financial incentives for MU.
NAICS	*North American Industry Classification System*: Categorizes businesses for use in economic reports and is used by BLS.
NBOMS	*Nevada Birth Outcomes Monitoring System*: Investigates the causes of birth defects and adverse birth outcomes, to develop preventive and mitigation strategies.
NCQA	*National Committee for Quality Assurance*: A nonprofit promoting evidence-based standards, including through collection of the CAHPS survey and official recognition of PCMHs.
NCU	*Nevada Check Up*: The State's children health insurance program (CHIP).
Nevada 2-1-1	*Nevada 2-1-1:* Free service that provides information about vital health and human service programs that are available throughout the state.
NGA	*National Governors Association*: The bipartisan organization of the nation's governors.
NHSC	*Nevada Health Service Corps*: Offers loan repayment assistance for health care professionals to practice in underserved areas, and is similar to the National Health Service Corps, in which Nevada also participates.
NICU	*Neonatal Intensive Care Unit*: Specializes in newborn treatment.
NIMH	*National Institute of Mental Health*: An institute within the National Institutes of Health.
NORC	*NORC at the University of Chicago*: An independent research organization and the University of Chicago and a CMMI technical assistance vendor.
NOSP	*Nevada Office of Suicide Prevention*: Responsible for the development, implementation and evaluation of the NSPP.
NSPP	*Nevada Suicide Prevention Plan*: The state plan to implement numerous suicide prevention efforts across the state in collaboration with various stakeholders.
P4P	*Pay for Performance*: The payment amount depends upon the quality of received services.
PA	*Physician Assistant*: A state-licensed health care professional that practices as a member of a team with physicians and other providers.

TERM	DEFINITION
PATH	*Projects for Assistance in Transition from Homelessness*: Assists individuals in accessing mental health services, applying for housing assistance and/or maintaining current housing.
PCA	*Nevada Primary Care Association*: A nonprofit organization and the federally designated Primary Care Association for assisting health centers and other safety-net providers in Nevada.
PCMH	*Patient-Centered Medical Home*: A primary care practice where a personal physician is responsible for directing the coordinated and integrated delivery of safe and quality whole person care.
PCP	*Primary Care Physician* or *Provider*: The primary point of contact for a patient providing initial diagnoses and continued care, and a physician, physician assistant or nurse practitioner.
PEBP	*Public Employees Benefit Program*: Covers over 33,000 public employees in Nevada.
PHCS	*Public Health and Clinical Services*: A State of Nevada program providing public health nursing.
PHI	*Protected Health Information*: Any health or payment data that can be linked to a specific patient.
PHIC	*Population Health Improvement Council*: The overarching component of the governing body for implementation of the Nevada SHSIP.
PMPM	*Per Member Per Month*: A commonly used method for calculating prospective capitated payments to providers.
Project ECHO	*Project Extension for Community Healthcare Outcomes*: Telehealth project that connects primary care physicians in rural areas to specialist physicians.
PSEP	*Professional Student Exchange Program*: Assists students in a variety of critical access fields to study out-of-state, as part of WICHE.
Q#	*Calendar Year Quarter:* Q1: January - March, Q2: April - June, Q3: July - September, Q4: October - December
Quarter	*Quarters*: Are based on the calendar year instead of the state fiscal year.
QPR	*Quarterly Progress Report*: Provides regular updates to funders.
QRDA	*Quality Reporting Data Architecture*: A standard structure for electronic reporting of quality data from individual providers.
QRDA III:	*Quality Reporting Data Architecture - Category III*: A standard structure for aggregate data of a specified population of patients within a particular health system.
REC	*Regional Extension Center*: Source of support and resources for providers to implement and use of electronic health records.
REMI	*Regional Economics Model, Inc.*: Model that considers the historic relationships between the state economy, demographics and the national economy.
REMSA	*Regional Emergency Medical Services Authority*: A nonprofit providing emergency services, including triage to alternative destinations, in the Reno-Sparks area.
RFI	*Request for Information*: A formal process to solicit feedback from interested parties seeking potential solutions.
RFP	*Request for Proposal*: A formal procurement process to obtain business proposals from vendors.
ROI	*Return on-Investment*: Financial comparison of costs and gains.
RTC	*Residential Treatment Center*: Provides live-in therapy for substance abuse, behavioral problems or mental illness.
SAMHSA	*Substance Abuse and Mental Health Services Administration*: A division within HHS, providing support and funding related to substance abuse and mental illness.

TERM	DEFINITION
SAPTA	*Substance Abuse Prevention and Treatment Agency*: A State of Nevada agency that develops the state plan for prevention and treatment and that coordinates state and federal funding.
SHADAC	*State Health Access Data Assistance Center*: CMMI technical assistance vendor.
SHSIP	*State Health System Innovation Plan*: Nevada's road map to reform payment systems and health care delivery, in order to increase access, improve health and contain costs.
SIDS	*Sudden Infant Death Syndrome*: Unexplained death of an infant usually during sleep.
SIM	*State Innovation Model*: An initiative to design, implement and evaluate new payment and service delivery models to promote broad health system transformation.
SMHP	*State Medicaid Health Information Technology Plan*: The state-led plan for HIT.
SNAP	*Supplemental Nutrition Assistance Program*: Provides low-income Americans with benefits to purchase food and is operated by the Food and Nutrition Service of USDA.
SNF	*Skilled Nursing Facility*: Provides assistance with daily activities and skilled medical care for acute and chronic conditions.
SPA	*State Plan Amendment*: Negotiated between states and the Centers for Medicare & Medicaid Services, to approve program changes.
SPMI	*Severe and Persistent Mental Illness*: Mental illness resulting in serious functional impairment, substantially interfering or limiting activities.
STAT	*Strategic Technical Assistance Team*: A model that makes time-limited staff available to providers for onsite training and resource sharing to support practice transformation success.
STD	*Sexually Transmitted Disease (or STI - Sexually Transmitted Infection)*: Includes a variety of viruses, bacteria and parasites transmissible through sexual contact and, variably, through other modes such as blood or vertical transmission between mother and child.
Super-utilizer	*Super-utilizer:* Beneficiaries with complex, unaddressed health issues and a history of frequent encounters with health care providers.
TANF	*Temporary Assistance for Needy Families*: Operated by HHS and provides temporary financial aid up to 60 months for needy families.
TMCC	*Truckee Meadows Community College*: Offers a community health worker training program.
Triple Aim	*Triple Aim:* A model conceptualized by the Institute for Healthcare Improvement and adopted by CMS, which seeks to improve care, improve population health and control costs.
UME	*Undergraduate Medical Education*: Education related to becoming a medical practitioner.
UNLV	*University of Nevada Las Vegas*: Hosts the Center for Health Information Analysis for Nevada and introducing a school of medicine with an anticipated inaugural class in 2017.
UNSOM	*University of Nevada School of Medicine*: Based in Reno and provides support to rural health data analysis and telehealth initiatives, including Project ECHO.
USDA	*U.S. Department of Agriculture*: A cabinet-level agency of the federal government.
VBP	*Value-Based Purchasing*: Implements pay-for-performance of health providers, and uses monetary rewards, penalties or both.
VISN	*Veterans Integrated Service Network*: Component of the U.S. Department of Veterans Affairs that implements medical assistance programs.
WIC	*Women, Infants and Children Program*: Promotes and protects the health of women of childbearing age, infants, children and adolescents, including children and youth with special health care needs.
WICHE	*Western Interstate Commission for Higher Education*: Works to increase access to higher education for students, allowing Nevadan students to attend out-of-state schools at reduced tuition rates.

XIV. ATTACHMENT C: SIM STAKEHOLDERS

Health Information Technology and Data Taskforce	
Name	**Title and Organization**
Sarah Albers	Senior Analytic Consultant, Truven
Brett Barton	Sales Executive, HP Enterprise Services
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Nancy Boland	County Commissioner, Esmeralda County
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Karri Couste	DHHS
Ellen Crecelius	Deputy Director Fiscal, DHHS
Steven Decker	Executive Director, Family Support Council of Douglas County
Ron Fuschillo	Chief Information Officer, Renown
Joseph Greenway	Director, Center for Health Information Analysis - UNLV
Tim Hakamaki	Sr. Director, Data Solutions, Sansio/Physio-control Data Solutions
Deborah Huber	Executive Director, HealthInsight Nevada
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Sarah McCrea, EMTP, RN	EMS Quality Improvement Coordinator, Las Vegas Fire and Rescue
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Keith Parker	HealthInsight Nevada
Patrick Patterson	Truven
Julia Peek	DHHS
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Sandie Ruybalid	IT Manager, DHCFP
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Dena Schmidt	Deputyy Director, DHHS
David Stewart	Deputy Administrator, Information Systems, DWSS
Troy Tuke	EMS Coordinator, Clark County Fire Department
Chris Watanabe	Remsa
Rob Waters	Vice President of Development, Healthcare IT Connect
Andrea West	Truven
Richard Whitley	Director, DHHS
Blong Xiong	Director, Consulting, Truven
Marty Bobroske	Truven

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Name	**Title and Organization**
Chad Westom	Bureau Chief, Bureau of Health Statistics, Planning and Response
Chris Bosse	Vice President of Government Relations, Renown
Debra Scott	Executive Director, Nevada State Board of Nursing
Douglas Geinzer	Chief Executive Officer, Las Vegas Heals
Elyse Monroy	Policy Analyst, Office of Governor Brian Sandoval
Grace Campbell	Regional Director, AHIP
Grayson Wilt	Nevada State Medical Association
Laura Hale	Manager, Primary Care Office, DHHS/DPBH
Joan Hall	President/CEO, Nevada Rural Hospital Partners
John Hammond	EMS & Trauma System Supervisor, SNHD
Justin Jones	Senator, Chair, Nevada State Senate, Legislative Committee on Health Care
Robert Kidd	President, NVHCA—Perry Foundation
Robin Reedy	NSMA
Jess D. Rosner	Tonopah Programs Coordinator, Nye Communites Coalition
Katie Ryan	Director, Communications and Public Policy, Dignity Health
Rosemary Englert	Senior Legislative and Regulatory Analyst, AHIP
Stacy Woodbury	Executive Director, Nevada State Medical Association
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Deborah Aquino	Oral Health Program Manager, Division of Public and Behavioral Health

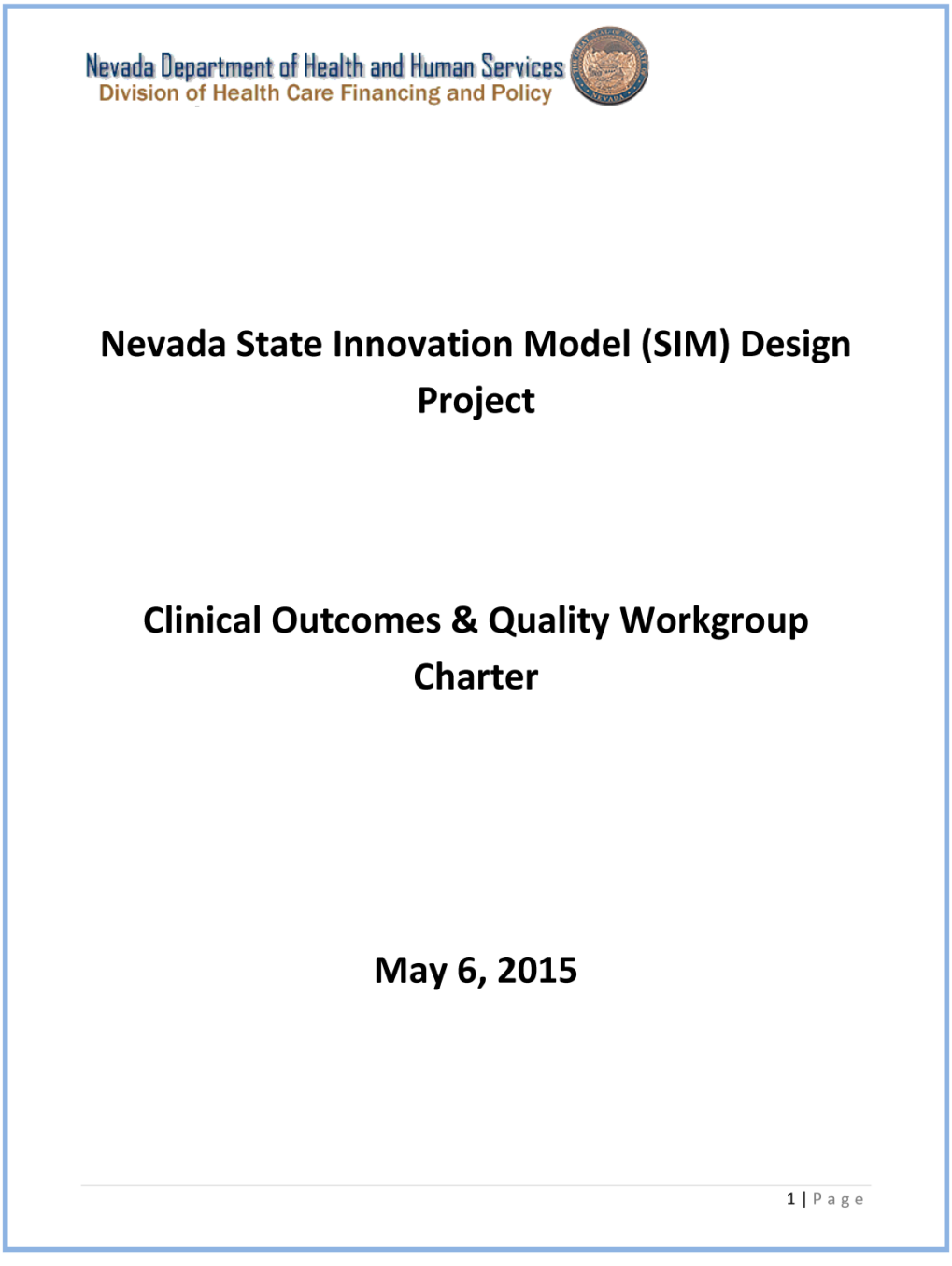
Patient Focused Workgroup	
Name	**Title and Organization**
Anthony Allman	CEO, POS REP
Anna Cedro	Executive Director, Care Coalition
Maria Laroya	Social Work Case Manager, Amerigroup
Barbara Carter	Program Coordinator, YMCA Diabetes Prevention Program
Breezy Bolden	YMCA Branch Executive, YMCA Diabetes Prevention Program
Christy McGill	Director, Healthy Communities Coalition
Daryl Crawford	Executive Director, Inter-Tribal Council of Nevada
Erin Snell	Program Director, Behavioral Health, Nevada Health Care Guidance Program
Heidi Eikom	Community Health Nurse (RN), Indian Health Service
Jane Gruner	Administrator, ADSD
Altamit Lewis	Behavioral Health Manager, Amerigroup
Kelly Wooldridge	Deputy Administrator, Children's Mental Health Services, DCFS
Ken Retterath	Washoe County Social Services
Laura Oslund	Coalition Director/Community Educator, Nye Communities Coalition
Lisa Barnum	RN, PBT
Janie Ripptoe	MHTIII, Caliente Behavioral Health
Michael Corti	Executive Director, Nevada Community Prevention Coalition, Inc.
Patricia O'Rourke, RN	Advocate, Your Health Matters
Phyllis Fryer	Vice President of Marketing and Communications, Renown
Steve Eisen	Chief Executive Officer, Children's Heart Center Nevada
Steven Tafoya	Manager, EMS Program, Division of Public and Behavioral Health, Emergency Medical Systems
Susan McCourt	RN Patient Advocates of Southern Nevada, Member/Advocate
Vilma Manalo Gorre	Executive Director, Community Alliance Network and Developmental Outreach
Williams Evans, M.D.	Founder, Co-Director, Children's Heart Center Nevada
Stacey Stewart	CEO, UPbrella
Maya Zamir	Manager II, Healthcare Management Services, Amerigroup

Provider Workgroup	
Name	**Title and Organization**
Lawrence Barnard	CEO, UMC
Brian Brannman	Dignity Health
Charmaane Buehrle	Director, Business Development, West Hills Hospital
Abby Burkhart	RN CHNII, State of Nevada Division of Public and Behavioral Health
Steve Burt	CEO, Ridge House
Annabelle Cruz	Executive Coordinator to Todd Sklamberg, Sunrise Hospital
Richard Davis	Adult Lung Health Program Manager, American Lung Association in Nevada
Lisa Dettling	Vice President, Nevada Health Centers
Lisa Farnan	Vice President, Managed Care, Dignity Health, St. Rose Dominican
Dan Galles	Chief Financial Officer, Saint Mary's Regional Medical Center
Nancy Hook	Executive Director, Nevada Primary Care Association
Todd Lincoln Jackson, M.D.	President and M.D., Jackson Ophthalmology Group, Prestige Laser & Cataract Institute
Mike Johnson, M.D.	Medical Doctor
Fergus Laughridge	Captain, Humboldt General Hospital EMS Rescue
Rudy Manthei	Physician, Manthei Management Services, Lorenz Ophthalmology Center, Nevada Eye & Ear, Seven Hills Surgery Center, LLC, Stonecreek Surgery Center, LLC
Deborah Osborn	Administrator, Keeping the Smiles
Carol Reitz	Support Staff, Nevada Commission on Autism Spectrum Disorders
Todd Sklamberg	Chief Executive Officer, Sunrise Hospital & Medical Center/Sunrise Children's Hospital
Ivy Spadone	Chief Operations Officer, Northern Nevada HOPES
Larry Trilops	Senior Vice President and CEO Network Development, Renown
Grayson Wilt	Nevada Stated Medical Association
Mark Zellmer	Director of Resident Services, Nevada Hand

Delivery System and Payment Alignment Workgroup	
Name	**Title and Organization**
Jami Berger	Noridian Healthcare Solutions
Bobbette Bond	Co-Founder, Nevada Health Co-op
Brandi Brashear	Reimbursement Director, Dignity Health
Charles Duarte	Chief Executive Officer, Community Health Alliance
Steve Fisher	Administrator, DWSS
Christian Garaycochea	Owner, Office Anesthesia Consultants, LLC
Kirk Gillis	Vice President of Accountable Care, Renown
Nevada Griffin	McKinsey & Company
Linda Griglun	Director, Cost of Care, Anthem
Philip Hanna	CEO, Battle Mountain General Hospital
Jeanine Hawkins	Provider Network Manager Sr., Anthem Blue Cross Blue Shield
Allyson Hoover	Amerigroup
Deborah Huber	Executive Director, HealthInsight Nevada
Todd Lincoln Jackson, M.D.	President and M.D., Jackson Ophthalmology Group, Prestige Laser & Cataract Institute
Kristina Jones	Senior Project Coordinator/Medicaid Operations, Health Plan of Nevada—UHC
Eric Lloyd	Amerigroup
Deborah Loesch-Griffin	Director, Health Services Hub and Rural Nevada Health Network, Healthy Communities Coalition
Brooke Page	Grants Coordinator, Clark County Department of Social Services
Jerry Reeves, M.D.	Vice President of Medical Affairs, HealthInsight Nevada
Sherri Rice	President/CEO, Access to Healthcare Network
Bethany Sexton	Vice President Revenue Cycle, Renown
Stacey Smith	Executive Director, Nye Communities Coalition
Brenda Staffan	REMSA
Melissa Walker	Dignity Health
Jeanne Wendel	Economics Professor, Economics Department, University of Nevada, Reno
Gail Yedinak	Senior Management Analyst - Government Relations, University Medical Center of Southern Nevada
Sandeep Wadhwa, M.D.	Senior Vice President, Care and Delivery Management, Noridian Healthcare Solutions

Clinical Outcomes and Quality Workgroup	
Name	**Title and Organization**
Amir Bacchus, M.D.	Chief Medical Officer, Healthcare Partners
Angela Berg	RN, DNP Candidate, Children's Specialty Center of Nevada, Cure 4 the Kids Foundation
David Fiore, M.D.	Professor Family and Community Medicine, University of Nevada, Reno, Medical School
Tamara Foster	Operations Manager, Quality Assurance, Amerigroup
Gene Gantt	CEO, Eventa
Tracey Green, M.D.	State Health Officer, State of Nevada
Emilia Guenechea	Executive Director, REACH
Michael Howie	Executive Director, Mojave Adult, Child and Family Services, Inc.
Deborah Huber	Executive Director, HealthInsight Nevada
Gayle Hurd	Best Practices Administrator, Renown
Richard Jimenez	Senior Vice President, WestCare
Amy Khan	Medical Director, Nevada Medicaid Health Care Guidance Program—McKesson Care Management
Tami Kyburz Chartraw	Quality and Performance Improvement Manager, Nevada Division of Public and Behavioral Health
Brad Lee, M.D.	REMSA
Daniel Mathis	President and CEO, Nevada Health Care Association
Heidi Parker	Executive Director, Immunize Nevada
Jerry Reeves, M.D.	Vice President of Medical Affairs, HealthInsight Nevada
Dennis Rochier	Vice President of Revenue Cycle, Renown
Jason Schwartz	Director of Community Support Services, Mojave Adult, Child and Family Services, Inc.
Thomas Schwenk	Dean, University of Nevada School of Medicine
Bill Welch	President/CEO, Nevada Hospital Association

XV. ATTACHMENT D: SAMPLE PROJECT CHARTER



Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Nevada State Innovation Model (SIM) Design Project

Clinical Outcomes & Quality Workgroup Charter

May 6, 2015

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Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Background

On December 16, 2014, CMS awarded the Nevada Department of Health and Human Services (DHHS) a $2M State Innovation Model (SIM) design grant. This grant provides financing and technical assistance from the Centers for Medicare and Medicaid Services (CMS) to design models that will transform health care delivery systems in states while improving population health, improving the patient experience, and lowering cost. These three goals – improving population health, improving the patient experience, and lowering cost- are known as the CMS Triple Aim.

The deliverable under this grant is a design model that will be presented to CMS in the form of a State Health System Innovation Plan (SHSIP). The SHSIP will serve as the Nevada roadmap to achieving the CMS Triple Aim. The SHSIP will be considered by CMS in the event additional grant funding is made available to implement and test the model outlined in the plan.

A successful Nevada SHSIP will require broad stakeholder input and engagement. One of the mechanisms to gain this input and engagement is through the formation of workgroups and taskforces with a specific purpose for each.

Purpose of this Charter

This Project Charter serves several purposes:

- Identifies the goals and anticipated activities of the workgroups and taskforces formulated to assist DHCFP with designing the SIM State Health System Innovation Plan
- Establishes the roles, responsibilities, and expectations of the participants who are participating on behalf of and with the executive support of their organization
- Upon signoff, provides authorization of the participant to participate in the workgroups/taskforces
- Serves as the point of reference for documentation and work product of the workgroups/taskforces
- Establishes agreement of the deliverables between the Division of Health Care Financing and Policy (DHCFP) and the workgroup/taskforce members.

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Goals Statement:

The SIM Workgroups and Taskforces are vital contributors to the Nevada SIM Design Project. The mission of the NV SIM Design Project is to:

- Improve access to care for Nevadans
- Improve the health status of Nevadans
- Align healthcare delivery and payment systems
- Contain healthcare costs while increasing healthcare value

While critical, the participant role in the workgroup/taskforce forum is advisory in nature. These participants will provide input into the Nevada SIM Model Design project based on the stakeholder's experience with the Nevada health care delivery system. The workgroups and taskforces will concentrate on input that will achieve the CMS Triple Aim, align with Governor Sandoval's seven (7) health services core functions (see page 7), and achieve the goals listed above.

At a global level, participants are requested to consider:

- Successes and shortcoming of the current health care delivery system
- Opportunities for meaningful and sustainable change
- Critical design features necessary for success
- How success will be measured
- Availability and accessibility of data necessary to implement and evaluate proposed solutions
- Fiscal and operational sustainability of solutions offered

The Clinical Outcomes & Quality Workgroup's purpose and suggested areas for discussion are found on page 9 of this document. The list is provided as a starting point for discussion and should stimulate participants' thought process. Participants should make sure discussion remains germane to their charge, but they should not be constrained by the topics listed. A list of all workgroups and taskforces are found on pages 8-10 to give a broader perspective of where certain topics may be being discussed.

The input from this and other workgroup/taskforce forums will be utilized by DHCFP Leadership to formulate the State Health System Innovation Plan (SHSIP).

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Workgroup/Taskforce Members:

To ensure a manageable forum for input, participation in the meetings will be kept to a relatively small but representative size of volunteer members. The members of the Policy & Regulatory Taskforce are:

- Amir Bacchus, MD. Chief Medical Officer, Healthcare Partners
- Angela Berg, Children's Specialty Center of Nevada, Cure 4 the Kid's Foundation
- David Fiore, MD, Professor Family and Community Medicine, UNR Medical School
- Tamara Foster, Operations Manager, Quality Assurance, Amerigroup
- Gene Gantt, CEO, Eventa
- Tracey Green, MD, State Health Officer, State of Nevada
- Michael Howie, Executive Director, Mojave Adult, Child and Family Services, Inc.
- Deborah Huber, Executive Director, HealthInsight Nevada
- Gayle Hurd, Best Practices Administrator, Renown
- Richard Jimenez, Senior Vice President, WestCare
- Amy Khan, Medical Director, Nevada Medicaid Health Care Guidance Program, McKesson Care Management
- Tami Kyburz Chartaw, Quality & Performance Improvement Manager, Nevada Division of Public and Behavioral Health
- Brad Lee, MD, REMSA
- Daniel Mathis, President CEO, Nevada Health Care Association
- Jerry Reeves, MD, Vice President Medical Affairs, HealthInsight, Nevada
- Dennis Rochier, Vice President Revenue Cycle, Renown
- Jason Schwartz, Director of Community Support Services, Mojave Adult, Child and Family Services, Inc.
- Thomas Schwenk, Dean, University of Nevada School of Medicine
- Bill Welch, President CEO, Nevada Health Association

Each member serves at the pleasure of the DHCFP Administrator.

Workgroup/Taskforce Activities

- Development of the population health plan
- Define population health measures to be addressed and strategies for improvement
  - Must include: Obesity, Tobacco Cessation, and Diabetes
  - Identify other areas for improved outcomes and/or reduced disparities
- Identify clinical outcome measures and quality markers that will be used to measure and assess improvement for each initiative
  - Determine data sources, and methodologies to measure each outcome/quality measure
- Feasibility of common clinical practice guideline endorsement across multiple payers

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Meeting Expectations:

All Participants shall:

- Conduct a thorough review of SIM materials provided by DHCFP in advance of the meeting
- Arrive to meetings timely and actively participate in the full meeting
- Solicit feedback from relevant peers, associates, etc. prior to the session
- Approach discussions with a fair, balanced, and professional perspective
- Provide feedback on draft documentation reflecting session outputs

Meeting Frequency:

The workgroup and taskforce meetings are envisioned to begin on or about the first week of May 2015. The sessions will be a two (2) to three (3) hour facilitated working session with in-person attendance strongly encouraged. The workgroups and taskforces are expected to reconvene approximately every three weeks through the end of August 2015. Note that the frequency of meetings may be greater or less than anticipated in order to meet the needs of the project. After the anticipated conclusion of the stakeholder input period (August 2015) and at various times afterward, workgroup and or taskforce members (in whole or individually) may be asked to assist DHCFP with the model design or other aspects of this project.

To ensure both urban and rural input, engagement, and representation, the workgroup/taskforce member selection process will take participants' location into consideration. While in-person attendance at workgroup and taskforce meetings is highly preferred, efforts will be made to utilize teleconferencing, webinars, or other technology when necessary to minimize travel and promote a balanced representation of urban and rural participants.

All attempts will be made to provide meeting notice and related meeting materials to all members by electronic mail at least five (5) business days prior to the meeting date.

Reimbursement:

Participants are not eligible for compensation or reimbursement from DHCFP for time, travel, or other expenses related to their participation in the workgroups or taskforces.

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Timeframes:

Activity	Timeframe/Date	Responsibility
Notice of Meeting Issued	Approximately two weeks prior to meeting date	Myers and Stauffer, LC
Distribution of Meeting Materials	Five business days prior to meeting date	Myers and Stauffer, LC
Facilitated Meeting	Approximately every three weeks beginning the first week of May 2015 through the end of August 2015	All
Provide Draft Sessions Summary	No later than 5 business days after session	Myers and Stauffer, LC
Provide feedback on draft summary	No later than 3 business days after receipt of draft document	Workgroup/Taskforce Members
Provide DHCFP with Summary	No later than 10 business days after session	Myers and Stauffer, LC
Finalize Summary		DHCFP

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Governor Sandoval's Seven (7) Health Services Core Functions:

- ***Access to Affordable Health Care*** – Improve access to quality affordable, high quality health care
- ***Prevention*** - Increase awareness and opportunities for Nevadans to receive preventive care and instruction to safeguard against or reduce the impact of injury, illness, and infectious disease
- ***Wellness*** - Educate, encourage and empower Nevadans to take responsibility for their own health by engaging in healthy lifestyle activities resources and choices
- ***Chronic Disease*** - Build awareness of, and provide services for, the most dangerous risk factors which cause the greatest number of deaths and highest medical costs
- ***Quality*** - Ensure health services are provided in a quality environment and manner which improve health outcomes
- ***Pregnancy*** - Increase the percentage of women who seek appropriate care during pregnancy
- ***Mental Health***- Provide accessible and affordable mental health services to people of all ages

Accessed from: http://budget.nv.gov/StateBudget/Priorities_and_Performance_Based_Budget/page 3, February 10, 2015

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Taskforce and Workgroup Purpose and Areas for Discussion

Health Information Technology and Data Taskforce

- Data sources and availability
- Standardization of data and data elements
- Data integration and analytics tool
- Use of regional or independent Health Information Exchange data
- Explore opportunities to encourage development of a NV statewide HIE
- Promoting further adoption and meaningful use of electronic medical records
- Receive and research feasibility of obtaining and making available data that will be needed to support the Value Based Purchasing and Clinical Outcomes and Quality Workgroups

Policy and Regulatory Taskforce

- Evaluates input from other work streams to evaluate the impact of current or envisioned policies and regulations
- Identifies policy or regulatory barriers and opportunities to execute the innovation plan components
- Develops a pathway for alternative policy or regulations that may be necessary
- Ensures policy alignment with innovation plan components

Provider Workgroup

- Assess current and future provider workforce capacity
- Identify short-term and long-term strategies to improve access as well as NV health provider workforce capacity
- Identify network deficiencies common to all payers involved as well as drivers behind network disparities across payers
- Explore alternatives to traditional access modalities (ex. Telemedicine, teledentistry, telepsychiatry, paramedicine, role of Public Health Departments, etc.)
- Explore changes needed for Graduate Medical Education and academic pathways and funding sources for students to pursue health care careers
- Address issues affecting providers in rural versus urban settings
- Identify tools such as enhanced or greater penetration of health information technology needed by providers to achieve desired clinical outcomes and quality improvements
- Explore value based purchasing from the provider perspective (level of interest, concerns, minimum components of a VBP program from provider perspective, etc.)
- Identify unique provider needs and characteristics in an urban versus rural setting

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Delivery System and Payment Alignment Workgroup

- Explore need/desire for Patient Centered Medical Homes and or Health Homes for certain subsets of the NV population
- Is there a role for Accountable Care Organizations (ACOs) in the NV delivery system
- Develop a model to integrate behavioral health and physical health
- Accountability of providers for health outcomes of attributed patients
- Tools needed by providers to be successful under alternative delivery system models proposed
- Identify and address opportunities to achieve greater payer alignment
- Develop a strategic vision that will define and guide the NV SIM VBP effort
- Define a patient attribution model
- Decide if payment strategies will be set at payer level or multi-payer level
- Develop value based payment approach and methodology for initiatives identified by the Clinical Outcomes and Quality Workgroup
- Identify data needs and sources
- Identify any unique differences or considerations of the model for urban versus rural settings

Clinical Outcomes and Quality Workgroup

- Define the population health objectives to be accomplished
- Identify disease states, conditions, or populations by order of priority to be addressed through specific initiatives under this project
- Decide if common clinical practice guidelines are acceptable for specified areas of intervention and are feasible across multi-payers
- Define multi-payer structure to promote uniform messaging regarding clinical practice guidelines, best practices, and standards of care
- Identify clinical outcome measures and quality markers that will be used to measure and assess improvement for each initiative
- Identify data needs, data sources, and methodologies to measure each outcome/quality measure
- Ensure measures provide timely and early feedback on interim progress or develop lead measures that do so
- Decide if measures will be at a payer or multi-payer level or both.
- Identify tools needed by providers to achieve desired clinical outcomes and quality improvements
- For areas identified for population health improvement, identify level of patient engagement including methodologies to measure and improve patient engagement

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Patient Focused Workgroup

- Patient perspective on experience with the healthcare system (what works, what doesn't work, what is needed from the patient perspective, etc.)
- Issues or opportunities related to eligibility or enrollment
- Are challenges or concerns faced by patients in a rural setting different from those in an urban setting?
- Identify social determinants impacting health of Nevadans
- Identify unmet patient needs in the NV healthcare system
- Opportunities for improved patient knowledge of prevention, wellness, and health care conditions
- Identify tools and other resources that may be necessary to drive improved patient engagement in their health and health care

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Workgroup/Taskforce Charter Agreement and Approval:

Workgroup/Taskforce Charter Agreement and Approval

These signatures indicate our collective understanding and the advisory capacity of this stakeholder focus group. Further, the Charter represents our agreement to the goals, activities and deliverables defined by this charter and to support it with the appropriate time and commitment required.

DHCFP Signature	Date
Participant	Date

XVI. ATTACHMENT E: ELECTRONIC SURVEY RESULTS

Nevada State Innovation Model (SIM) Grant
Stakeholder Engagement Process
Results of Survey Monkey Tool

In an effort to increase stakeholder engagement and solicit input from a broad base of participants, a survey tool was launched during the first week of March 2015. The survey consisted of 27 questions and took on an average of 22 minutes to complete. The following is a synopsis of results from that survey.

Breakdown of Questions on the Survey

Nine questions pertained to basic demographics that included respondent's information, the location of the respondent (urban or rural) and what area of health care the respondent is employed in.
Three questions inquired if the respondent was interested in participating in a focus group and if they desired to receive future correspondence regarding the SIM grant.

Eight questions were devoted to ideas the respondents had regarding new or innovative health care reform programs that could potentially be used as part of the planning of the State Health System Innovation Plan. Questions were included to determine if the respondent was already involved in any SIM pertinent initiatives.

The remaining seven questions of the survey were used to assess what features or areas of interest the respondent thought important that the SIM grant address and the ranking of those initiatives. The rating average for each of those questions is presented in pages 2 through 4 of this document.

Results

- **Total Respondents (94):** 91 completed and 3 skipped (no answers) surveys. The respondents classified themselves as follows: Payer (7), Hospital (7), Behavioral Health (7), EMS (6), Member/Advocate (5), Physician (5), FQHC/RHC/Clinic (5), Vendor or Potential Vendor (3) and Nursing Home (1). The other 45 responses fell under the "Other" category.
- **Time Frame of the Survey:** 03/06/15 – 05/29/15 (date last survey taken)
- Of the 91 respondents, **68 responded from an urban area** (Washoe County, Clark County or Carson City) and **23 responded from a rural area**
- Of the 91 respondents, **79 were interested in serving on a focus group, 12 were not**
- Of the 91 respondents, **90 stated they would like to receive future correspondence regarding the SIM project**
- **45 of the respondents were actively involved in existing health care improvement initiatives.**
- **30 respondents entered information regarding projects they would like to see addressed.** Projects included: a team based approach to care, the use of Community Health Workers, an office based surgery initiative, plans that included the expansion of the roles of Emergency Medical Services, plans that addressed population specific issues and real time communication between providers via a web

based portal. These responses were compiled and reviewed by the SIM Team for potential inclusion in the SIM plan.

Rating Average for questions regarding SIM Subject Matter

Question 20: Please rank the importance of the following features that should be considered in transforming the NV healthcare delivery system where 1 is the most important and 7 is the least important.

Results (Most Important to Least Important)	Rating Average
Access to Care	2.05
Prevention	3.51
Quality and Outcomes	4.12
Chronic Disease Management	4.17
Behavioral Health	4.27
Wellness	4.57
Prenatal Care	5.03

Question 21: To what extent do you agree or disagree that the Nevada model should address the following:

Results (Most Important to Least Important)	Rating Average
Improved coordination of care	1.13
Better access to care	1.15
Improved quality and health outcomes	1.21
Increased patient involvement in their health care	1.36
Payment reform	1.53
Reduced health care expenditures	1.55
Development of Patient Centered Medical Homes	1.89
Multi-payer initiatives	1.98
Development of Affordable Care Organizations	2.11

Question 23: Please rank, in order of importance, the following opportunities for improvement in the NV health care delivery and payment system, where 1 is the most important and 7 is the least important (use each number only once). If you do not add "Other" features, rank "Other" as 6 and 7.

Results (Most Important to Least Important)	Rating Average
Increased number of Providers/Specialists	2.03
Expanded role of physician extenders (PA, APRN, etc.)	3.25
Increased use of telemedicine/telehealth	3.32
Ability to get an appointment timely	3.52
Improved non-emergency transportation services	4.16

Question 24: Improved Health Outcomes: Rank the importance of each of the following features in improving health outcomes where 1 is the most important and 6 is the least important (use each number only once). If you do not add "Other" features, rank "Other" as 5 and 6.

Results (Most Important to Least Important)	Rating Average
Providers understand and follow clinical practice guidelines	2.19
Patient electronic health information is available at the point of care	2.33
Patients follow health care provider instructions	2.69
Ability to measure outcomes and quality	2.69

Question 25: Reduced Total Health Care Expenditures: Rank the importance of each of the following features in reducing total health care expenditures where 1 is the most important and 6 is the least important (use each number only once). If you do not add "Other" features, rank "Other" as 5 and 6.

Results (Most Important to Least Important)	Rating Average
Providers use clinical practice guidelines appropriately	2.41
Payment for outcomes and quality vs volume of services	2.54
Patients follow health care provider instructions	2.58
Patients attend scheduled appointments	2.98

Question 26: Payment Reform: Rank the importance of each of the following features that should be considered when reforming Nevada's payment for health care services. This reform refers to moving from volume-driven payments to payments for quality and outcomes model. Please use the following criteria when answering: 1 is the most important and 7 is the least important (use each number only once). If you do not add "Other"

Results (Most Important to Least Important)	Rating Average
Payer and providers working together	2.33
Data and systems available to support new payment models	2.67
Recognition of the short term investment to realize a long term return	2.88
Fiscal impact of payment reform to payers and providers	3.39
Patients following health care provider instructions	3.64

Question 27: Increased Patient Engagement: Rank the importance of each of the following features in promoting increased patient involvement in their health care where 1 is the most important and 4 is the least important (use each number only once). If you do not add "Other" features, rank "Other" as 3 and 4.

Results (Most Important to Least Important)	Rating Average
Patient knowledge of disease state and impact of patient behavior on health status and outcomes	1.31
Patient knowledge of the cost of health care	2.09

XVI. ATTACHMENT F: NEVADA SIM DRIVER DIAGRAM

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
1	Redesign the health care delivery system to contain health care costs while increasing health care value	Challenging	Long-Term	1.1	Establish the Population Health Improvement Council (PHIC) to support and monitor statewide achievement of SIM aims.	Moderate	Short-term	1.1.1	Monitor execution of value-based purchasing (VBP) alignment strategies (pay for performance, bundled payments, alternative payment models (APM), etc.).	1.1.1-M1	By Q1 2016, the PHIC has met, and confirmed at least 4 payer participants.
										1.1.1-M2	By Q1 2016, the PHIC has met and developed a mission statement.
										1.1.1-M3	By Q2 2016, the MPC has reached agreement on key elements and definitions of VBP.
								1.1.2	Review and secure support for innovative service delivery models (super-utilizers, patient-centered medical homes, etc.).	1.1.2-M1	By Q1 2016, the PHIC has reviewed various service delivery models and secured support for identified models.
								1.1.3	Develop a STAT model that makes time-limited staff available for on-site training and resource sharing to support provider practice transformation success.	1.1.3-M1	By Q4 2017, on-site training and resources are available for deployment.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
				1.2	Increase the use of value-based purchasing (VBP) (e.g. pay for performance, bundled payments, alternative payment models (APM), etc.) in the state by all payers to improve acceleration and adoption of meaningful delivery system reform.	Challenging	Long-term	1.2.1	Align private and public VBP models in place.	1.2.1-M1	By Q2 2016, payers have adopted a framework for key components of VBP as approved by the MPC, including how the components are to be communicated to providers.
								1.2.2	Explore VBP approach in payer contracts with health care vendors (e.g. Public Employee Benefits Program (PEBP) contracts, Medicaid care management organization (CMO) and managed care organization (MCO) contracts).	1.2.2-M1	By Q4 2016, all MPC payers have reviewed and updated downstream contracts for opportunities to institute VBP alignment.
								1.2.3	Increase the usage of innovative VBP models.	1.2.3-M1	By Q2 2016, each MPC payer has reported the percentage of VBP, either by percentage of claims or patients.
										1.2.3-M2	By Q4 2018, MPC payers have increased from baseline by 20 percent.
				1.3	Develop and align programs to manage and improve health outcomes for super-utilizers of the health care system across payers.	Moderate	Mid-term	1.3.1	Work across payers to align the identification and interventions targeting high utilizers of care and ensure that they have an assigned PCP.	1.3.1-M1	By Q2 2016, MPC payers have developed a formula for identification of super-utilizers.
										1.3.1-M2	By Q3 2016, 95% of super-utilizers have been assigned to a PCP.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
								1.3.2	Ensure a care team is in place for identified super-utilizers.	1.3.2-M1	By Q1 2017, 80% of super-utilizers have been assigned to a care team.
								1.3.3	Ensure a treatment plan is in place for identified super-utilizers.	1.3.3-M1	By Q1 2017, 80% of super-utilizers have a treatment plan in place.
				1.4	Develop Medicaid Health Homes.	Moderate	Mid-term	1.4.1	Address duplication of service issues between delivery models.	1.4.1-M1	By Q1 2016, the Medicaid program has reviewed care/case management services across Patient-Centered Medical Homes (PCMH), MCOs and other program models to define the requirements for each model thereby reducing duplication of services.
								1.4.2	Develop a Nevada Medicaid Health Home and reimbursement model that complements the PCMH model.	1.4.2-M1	By Q2 2016, the Medicaid program has determined the formula for identification of the Medicaid Health Home (MHH) patients.
										1.4.2-M2	By Q2 2017, the federal authority and infrastructure to implement the MHH has been secured.
										1.4.2-M3	By Q1 2018, all individuals enrolled in a Health Home have been assigned to an actively engaged PCP monitoring the patient's treatment.
										1.4.2-M4	By Q4 2017, the Medicaid program has developed a monitoring plan for the effectiveness of the MHH.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
				1.5	Increase the number of Patient Centered Medical Homes (PCMH)s.	Challenging	Long term	1.5.1	Develop an aligned PCMH program and reimbursement model that may include tiered PMPM, quality incentives and infrastructure support.	1.5.1-M1	By Q3 2016, the MPC has agreement on an aligned PCMH reimbursement model.
										1.5.1-M2	By Q2 2017, the MPC payers have an aligned reimbursement approach in place and have made 100% of initial incentive payments for all components.
								1.5.2	Determine key elements of the PCMH delivery system model including attribution, provider directory management and measurement.	1.5.2-M1	By Q4 2016, the MPC has agreement on key elements of the PCMH model including attribution, provider directory management and performance measurement.
										1.5.2-M2	NCQA recognized PCMHs have increased from baseline of 294 facilities by 10% year over year until an optimal number has been reached.
								1.5.3	Develop technical assistance to support practice transformation and PCMH recognition.	1.5.3-M1	By Q4 2016, the MPC payers have developed a technical assistance program to support the goal to increase the percent of PCMH providers.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
2	Establish reliable and consistent access to primary and behavioral health care services	Moderate	Mid-term	2.1	Expand and align integration of Community Health Workers (CHWs) in health care system.	Low	Short-term	2.1.1	Develop reimbursement model for CHWs in Medicaid program.	2.1.1-M1	By Q2 2016, the Medicaid program has determined a reimbursement and delivery system model for CHWs.
										2.1.1-M2	By Q4 2016, all MPC payers have determined an aligned reimbursement model for CHWs.
								2.1.2	Ensure all payers are promoting the usage of CHWs to improve care coordination and health literacy.	2.1.2-M1	Trained CHWs have increased by 25 trainees per quarter until an optimal number has been reached.
										2.1.2-M2	Employed CHWs have increased from baseline by 10% year over year until optimal number has been reached.
				2.2	Expand and align telemedicine services.	Low	Short-term	2.2.1	Develop a task force for telemedicine services ensuring that a needs assessment is conducted.	2.2.1-M1	By Q1 2017, a needs assessment has been conducted to determine the reach of telemedicine and the number of additional presentations sites required to effectively improve access has been recommended.
								2.2.2	Establish additional telemedicine presentation sites to increase access of care.	2.2.2-M1	By Q4 2017, the number of recommended sites has been established.
				2.3	Expand and align use of community paramedicine services.	Low	Short-term	2.3.1	Explore reimbursement models to support and encourage the use of community paramedicine programs.	2.3.1-M1	By Q2 2016, reimbursement models to support the use of community paramedicine programs have been examined.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
								2.3.2	Expand community paramedicine programs in identified communities to support care coordination.	2.3.2-M1	By Q3 2016, a community paramedicine implementation roadmap has been conducted and made available for deployment to increase the number of community paramedicine programs in identified communities.
								2.3.3	Support and promote additional community paramedicine training.	2.3.3-M1	By Q4 2016, additional community paramedicine training is supported.
				2.4	Expand access to physician peer contacts through Project ECHO.	Low	Short-term	2.4.1	Conduct an assessment identifying the current reach of Project ECHO.	2.4.1-M1	By Q3 2017, an assessment has been completed identifying the current reach of Project ECHO, the percentage of providers who have access to additional specialist support, gaps and goals.
								2.4.2	Ensure that primary care physicians (PCPs) have access to specialists to support treatment decisions.	2.4.2-M2	By Q4 2019, the number of PCPs who have access to specialists has increased from baseline (as determined through the assessment) by 15 percent.
				2.5	Support providers routinely practicing at the highest levels of their scope of practice to improve access.	Moderate	Mid-term	2.5.1	Develop training and education to support awareness of existing scope of practice.	2.5.1-M1	By Q2 2018, training and education to support scope of practice has been developed.
								2.5.2	Ensure reimbursement policies supports appropriate use of practice levels.	2.5.2-M1	By Q3 2018, reimbursement policies that support appropriate use of practice levels have been reviewed, gaps identified and goals set.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
								2.5.3	Encourage utilization of certified staff as physician extenders (i.e. mid-wives, advanced practice nurses, nurse anesthetists and physician assistants).	2.5.3-M1	By Q4 2018, the utilization of physician extenders has increased from baseline by 20 percent.
				2.6	Promote Health Care Workforce Development.	Challenging	Long term	2.6.1	Identify opportunities to secure state funds sufficient to draw down full graduate medical education (GME) funds available to the state.	2.6.1-M1	By Q3 2018, the state has reviewed opportunities for GME, identified gaps and set new goals.
								2.6.2	Review loan forgiveness for physicians trained and remaining in rural areas for sustained practice period.	2.6.2-M1	By Q1 2018, the state has reviewed loan forgiveness programs, identified gaps and set new goals.
										2.6.2-M2	The number of practicing Nevada physicians in targeted health professional shortage areas has increased over baseline.
3	Improve quality health outcomes received by all Nevadans	Low	Short-term	3.1	Increase education and adoption of evidence-based components of tobacco cessation programs across payers.	Low	Short-term	3.1.1	Support marketing of Quitline and awareness of public health tobacco cessation programs.	3.1.1-M1	By Q1 2017, marketing has increased from baseline.
								3.1.2	Evaluate education awareness of risks involved with e-cigarettes.	3.1.2-M1	By Q1 2017, education awareness of risks involved with e-cigarette usage has been evaluated.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
								3.1.3	Partner with other payers to explore limiting administrative barriers (e.g. prior authorization) related to accessing tobacco cessation services.	3.1.3-M1	By Q4 2017, methods to reduce administrative barriers to accessing tobacco cessation services have been identified and prioritized for support.
				3.2	Promote a statewide, integrated behavioral health care system with youth and adult focus on prevention and early intervention as well as persons with Serious and Persistent Mental Illness (SPMI).	Moderate	Mid-term	3.2.1	Support current Substance Abuse and Mental Health Services Administration (SAMHSA) initiatives in Nevada.	3.2.1-M1	By Q3 2016, SAMHSA initiatives have been reviewed and prioritized to support the integration of physical health and behavioral health.
								3.2.2	Support Certified Community Behavioral Health Clinic (CCBHC) grant initiative to increase integration of physical health and behavioral health treatment.	3.2.2-M1	By Q3 2016, gaps to CCBHC initiative have been identified and prioritized for supporting improvement where supported by legislation.
								3.2.3	Support the use of technology by certified peer specialists for behavioral health treatment regimens for veterans and additional at-risk groups.	3.2.3-M1	By Q4 2017, peer support specialists are routinely utilizing supportive technology to maintain patient engagement.
								3.2.4	Support current Public Health suicide prevention initiative.	3.2.4-M1	By Q3 2016, gaps to the current Public Health suicide prevention initiative have been identified and prioritized for supporting improvement where supported by legislation.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
								3.2.5	Support the National Governor's Association (NGA) Medicaid Transformation Project which is seeking to transform the behavioral health system for Nevada's youth (ages 11 to 18 years) from a crisis-based service system to a system of prevention and early intervention.	3.2.5-M1	By Q3 2016, gaps to the NGA's Medicaid Transformation Project have been identified and prioritized for supporting improvement where supported by legislation.
				3.3	Promote increased healthy lifestyle practices and availability of obesity prevention programs for youth and adults.	Low	Short-term	3.3.1	Support Children's Heart Center pediatric obesity program.	3.3.1-M1	By Q3 2016, gaps to Children's Heart Center pediatric obesity program have been identified and prioritized for supporting improvement where supported by legislation.
								3.3.2	Continue components of expired Medical Incentives for Prevention of Chronic Diseases Grant.	3.3.2-M1	By Q3 2016, gaps to the Medical Incentives for Prevention of Chronic Diseases grant have been identified and prioritized for supporting improvement where supported by legislation.
								3.3.3	Support current Public Health obesity prevention grant.	3.3.3-M1	By Q3 2016, gaps to current Public Health obesity initiative have been identified and prioritized for supporting improvement where supported by legislation.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
				3.4	Increase implementation of best practices for diabetes management programs with an emphasis on prevention in the youth population.	Low	Short-term	3.4.1	Support current payers' diabetes programs including PEBP, MCOs and CMO.	3.4.1-M1	By Q4 2016, methods to align MPC payer diabetes programs have been identified and prioritized for supporting improvement where supported by legislation.
								3.4.2	Explore and support actions to increase the early identification of individuals with diabetes and those individuals at increased risk for diabetes, with emphasis on the youth population.	3.4.2-M1	By Q2 2017, actions to increase the early identification of individuals with diabetes and those individuals at increased risk for diabetes have been identified.
								3.4.3	Support current Public Health diabetes and prevention initiative through early intervention and focused on quality outcomes.	3.4.3-M1	By Q3 2016, gaps to Public Health diabetes and prevention initiative have been identified and prioritized for supporting improvement where supported by legislation.
				3.5	Increase evidence-based prevention and transitions of care management for patients with cardiovascular disease.	Low	Short-term	3.5.1	Support Million Hearts Initiative.	3.5.1-M1	By Q3 2016, gaps to the Million Hearts Initiative have been identified and prioritized for supporting improvement where supported by legislation.
								3.5.2	Support use of community paramedicine and CHW programs during transitions from inpatient to outpatient care for cardiac patients.	3.5.2-M1	By Q4 2016, methods to utilize community paramedicine and CHWs focused on cardiac care have been identified and prioritized for supporting improvement where supported by legislation.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
				3.6	Increase quality outcomes through focused efforts on early prevention programs for youth and adults.	Low	Short-term	3.6.1	Support improvement of prenatal care through current Public Health initiative.	3.6.1-M1	By Q3 2016, gaps to prenatal care initiatives have been identified and prioritized for supporting improvement where supported by legislation.
								3.6.2	Support improvement of prenatal care through use of CHWs to support new mothers in follow-up care.	3.6.2-M1	By Q4 2016, methods to utilize CHWs to support new mothers in follow-up care have been identified and prioritized for supporting improvement where supported by legislation.
								3.6.3	Support increase in well-child visits through PCMH and health information technology (HIT) infrastructure.	3.6.3-M1	By Q1 2018, the overall number of well-child visits for Nevadans under 21 years of age have increased from baseline by 10% year over year.
								3.6.4	Support increase in immunizations through PCMH and HIT infrastructure.	3.6.4-M1	By Q1 2018, the overall number of immunizations for adolescents and youth have increased from baseline by 10% year over year.
										3.6.4-M2	By Q1 2018, the overall number of flu vaccines for adults has increased from baseline by 10% year over year.
								3.6.5	Support increase of utilization of pharmacies to improve medication management.	3.6.5-M1	By Q4 2017, analysis and a work plan has been developed to increase utilization of pharmacies.
								3.6.6	Support awareness of sexually transmitted diseases (STD) prevention.	3.6.6-M1	By Q4 2017, methods to support increased STD prevention awareness have been implemented.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
				3.7	Implement evidence-based methods to reduce potentially preventable hospital admissions, readmissions and emergency department utilization.	Low	Short-term	3.7.1	Support usage of community paramedics and CHWs on follow-up care for at-risk patients.	3.7.1-M1	By Q3 2016, methods to utilize community paramedicine and CHWs to support at-risk patients in follow-up care have been identified and prioritized for supporting improvement where supported by legislation.
								3.7.2	Support increased usage of 2-1-1 and potential coordination of nurse help lines.	3.7.2-M1	By Q1 2018, utilization of 2-1-1, and similar call lines, have increased from baseline by 10% year over year until an optimal level has been reached.
								3.7.3	Support increased use of telemedicine to reduce hospital admissions, readmissions and emergency department utilization.	3.7.3-M1	By Q4 2017, methods to increase the use of telemedicine to support hospital and ED utilization reduction has been implemented.
								3.7.4	Support asthma control methods.	3.7.4-M1	By Q4 2017, the percentage of patients effectively using controller medications to manage asthma have increased.
										3.7.4-M2	By Q1 2018, the number of hospital emergency department encounters for asthma have been reduced.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
				3.8	Support improved patient experience.	Moderate	Mid-term	3.8.1	Support increased used of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital, Clinician & Group Surveys and Health Plan surveys to measure quality in key areas related to population health improvement.	3.8.1-M1	By Q2 2018, the number of surveys conducted to monitor key quality areas, as recommended by the PHIC, has increased.
										3.8.1-M2	By Q4 2019, the patient satisfaction score has increased year over year.
								3.8.2	Explore options to incentivize increased response rates for health surveys.	3.8.2-M1	By Q2 2018, options to incentivize increases response rates for health surveys have been reviewed and prioritized.
4	Foster greater Health Information Technology and Data Infrastructure **	Moderate	Mid-term	4.1	Promote statewide Health Information Exchange (HIE).	Challenging	Mid-term	4.1.1	Convene an HIE Collaborative to develop a plan to expand HIE connectivity.	4.1.1-M1	By Q2 2016, the HIE collaborative and structure are in place.
										4.1.1-M2	By Q3 2016, the plan to expand HIE connectivity has been developed.
								4.1.2	Increase direct messaging and notification systems to improve capacity for providers to exchange treatment information.	4.1.2-M1	By Q4 2017, statewide direct messaging and notification systems capability through HIE are operational.
								4.1.3	Increase number of providers connected to statewide HIE.	4.1.3-M1	By Q4 2019, the number of providers connected to statewide HIE have increased to no less than 65 percent of the total provider community.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
				4.2	Develop population health management and analytics tool.	Moderate	Mid-term	4.2.1	Procure and implement a population health tool to measure, track and publish population health metrics utilizing data elements from the statewide HIE, public health registries and the all-payer claims data repository (APCDR).	4.2.1-M1	By Q3 2016, a plan for implementing a population health tool for tracking population health metrics has been developed.
										4.2.1-M2	By Q1 2018, a population health tool to be used for value-based purchasing has been implemented.
										4.2.1-M3	By Q2 2018, a single provider portal that allows for accessing provider-specific metrics and patient information has been developed.
				4.3	Increase provider HIT technical assistance.	Moderate	Short-term	4.3.1	Incorporate an HIT toolkit for providers that will educate and promote the adoption, implementation and meaningful use of EHRs which complements the early work of the Regional Extension Center (REC) including workflows.	4.3.1-M1	By Q1 2017, a plan for implementation of a population health toolkit to support meaningful use has been developed.
				4.4	Utilize HIT to increase patient engagement, health literacy, and joint decision-making.	Moderate	Mid-term	4.4.1	Develop a centralized public portal with provider-level quality metrics so that individuals can make informed treatment decisions.	4.4.1-M1	By Q1 2017, a plan for implementation of a public portal for tracking and reporting quality metrics has been developed.
										4.4.1-M2	By Q4 2017, public portal for tracking and reporting quality metrics has been implemented.

A	AIM	Complexity	Time-line	PD	Primary Driver	Complexity	Time-line	SD	Secondary Driver	M	Metric
								4.4.2	Develop a centralized consumer portal providing health information guidance to Nevadans.	4.4.2-M1	By Q4 2018, a plan for implementation of a public portal for offering health empowerment content has been developed.
										4.4.2-M2	By Q4 2018, a public portal for offering health empowerment content has been implemented.
				4.5	Develop an All Payer Claims Data Repository (APCDR).	Moderate	Mid-term	4.5.1	Establish a repository of claims from all payers to assist in measuring population health and health care related activity.	4.5.1-M1	By Q1 2018, a plan for implementation of APCDR has been developed.
										4.5.2-M2	By Q4 2019, APCDR has been implemented.

****(Note - The development of Health Information Technology and Data Infrastructure is an integral, foundational component to support achievement of the first three aims.)**

Legend:

Timeline = Time for implementation vs time for observing outcome results.

Short-term = Under 2 years

Mid-term = Between 2 - 5 years

Long-term = 5 years or more

Complexity = Difficulty in implementing driver.

Low

Moderate

Challenging

XVII. ATTACHMENT G: CLINICAL AND POPULATION MEASURES

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS146v4	0002	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources	Percentage of children ages 2 to 18 years of age who were diagnosed with pharyngitis ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	NCQA
CMS137v4	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Clinical Process/ Effectiveness	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: - Percentage of patients who initiated treatment within 14 days of the diagnosis. - Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	NCQA
CMS156v4	0022	Use of High-Risk Medications in the Elderly	Patient Safety	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. - Percentage of patients who were ordered at least one high-risk medication. - Percentage of patients who were ordered at least two different high-risk medications.	NCQA

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS155v4	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Population/ Public Health	Percentage of patients ages 3 to 17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity	NCQA
CMS138v4	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/ Public Health	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI®)
CMS125v4	N/A	Breast Cancer Screening	Clinical Process/ Effectiveness	Percentage of women 40 to 69 years of age who had a mammogram to screen for breast cancer.	NCQA
CMS124v4	0032	Cervical Cancer Screening	Clinical Process/ Effectiveness	Percentage of women 21 to 64 years of age, who received one or more Pap tests to screen for cervical cancer.	NCQA

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS153v4	0033	Chlamydia Screening for Women	Population/ Public Health	Percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	NCQA
CMS130v4	0034	Colorectal Cancer Screening	Clinical Process/ Effectiveness	Percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer.	NCQA
CMS126v4	0036	Use of Appropriate Medications for Asthma	Clinical Process/ Effectiveness	Percentage of patients 5 to 64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	NCQA
CMS117v4	0038	Childhood Immunization Status	Population/ Public Health	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	NCQA

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS147v5	0041	Preventive Care and Screening: Influenza Immunization	Population/ Public Health	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	AMA-PCPI®
CMS127v4	0043	Pneumonia Vaccination Status for Older Adults	Clinical Process/ Effectiveness	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	NCQA
CMS131v4	0055	Diabetes: Eye Exam	Clinical Process/ Effectiveness	Percentage of patients 18 to 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	NCQA
CMS123v4	0056	Diabetes: Foot Exam	Clinical Process/ Effectiveness	Percentage of patients aged 18 to 75 years of age with diabetes who had a foot exam during the measurement period.	NCQA
CMS148v4	0060	Hemoglobin A1c Test for Pediatric Patients	Clinical Process/ Effectiveness	Percentage of patients 5 to 17 years of age with diabetes with an HbA1c test during the measurement period.	NCQA

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS134v4	0062	Diabetes: Urine Protein Screening	Clinical Process/ Effectiveness	The percentage of patients 18 to 75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	NCQA
CMS164v4	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Clinical Process/ Effectiveness	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.	NCQA
CMS154v4	0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Efficient Use of Healthcare Resources	Percentage of children 3 months to 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	NCQA

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS182v5	N/A	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Clinical Process/ Effectiveness	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).	NCQA
CMS135v4	0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/ Effectiveness	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	AMA-PCPI®

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS144v4	0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/ Effectiveness	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge	AMA-PCPI®
CMS161v4	104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinical Process/ Effectiveness	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	AMA-PCPI®
CMS128v4	105	Anti-depressant Medication Management	Clinical Process/ Effectiveness	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. - Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). - Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	NCQA

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS136v5	108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication	Clinical Process/ Effectiveness	Percentage of children 6 to 12 years of age and newly dispensed a medication for ADHD who had appropriate follow-up care. Two rates are reported. - Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. - Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.	NCQA
CMS169v4	N/A	Bipolar Disorder/Major Depression: Appraisal for alcohol or chemical substance use	Clinical Process/ Effectiveness	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	CMS
CMS140v4	387	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Clinical Process/ Effectiveness	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	AMA-PCPI®

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS62v4	N/A	HIV/AIDS: Medical Visit	Clinical Process/ Effectiveness	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.	NCQA
CMS2v5	418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/ Public Health	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	CMS
CMS68v5	419	Documenta-tion of Current Medications in the Medical Record	Patient Safety	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/ mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	CMS
CMS158v4	N/A	Pregnant women that had HBsAg testing	Clinical Process/ Effectiveness	This measure identifies pregnant women who had an HBsAg (hepatitis B) test during their pregnancy.	Optum

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS75v4	N/A	Children Who Have Dental Decay or Cavities	Clinical Process/ Effectiveness	Percentage of children, ages 0 to 20 years, who have had tooth decay or cavities during the measurement period.	CMS
CMS177v4	1365	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Patient Safety	Percentage of patient visits for those patients ages 6 to 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	AMA-PCPI®
CMS82v3	N/A	Maternal Depression Screening	Population/ Public Health	The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	NCQA
CMS74v5	N/A	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Clinical Process/ Effectiveness	Percentage of children, ages 0 to 20 years, who received a fluoride varnish application during the measurement period.	CMS

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS149v4	N/A	Dementia: Cognitive Assessment	Clinical Process/ Effectiveness	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period	AMA-PCPI®
CMS30v5	639	Statin Prescribed at Discharge	Clinical Process/ Effectiveness	Acute myocardial infarction (AMI) patients who are prescribed a statin medication at hospital discharge.	CMS
CMS71v5	436	Anticoagula-tion Therapy for Atrial Fibrillation/ Flutter	Clinical Process/ Effectiveness	Ischemic stroke patients with atrial fibrillation/ flutter who are prescribed anticoagulation therapy at hospital discharge.	The Joint Commission
CMS72v4	438	Antithrombotic Therapy By End of Hospital Day 2	Clinical Process/ Effectiveness	Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.	The Joint Commission
CMS100v4	142	Aspirin Prescribed at Discharge	Clinical Process/ Effectiveness	Acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge.	CMS
CMS104v4	435	Discharged on Antithrombotic Therapy	Clinical Process/ Effectiveness	Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.	The Joint Commission
CMS105v4	439	Discharged on Statin Medication	Clinical Process/ Effectiveness	Ischemic stroke patients who are prescribed statin medication at hospital discharge.	The Joint Commission

CMS eMeasure ID *(For Reporting in 2016)*	NQF #	Measure Title	CMS Domain	Measure Description	Measure Steward
CMS113v4	469	Elective Delivery	Clinical Process/ Effectiveness	Patients with elective vaginal deliveries or elective cesarean section births at >= 37 and < 39 weeks of gestation completed.	The Joint Commission
CMS185v4	716	Healthy Term Newborn	Patient Safety	Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.	CMS

Population Health Area	NQF Number	Quality Metric
Tobacco Cessation	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Behavioral Health	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
	105	Anti-depressant Medication Management
	108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
	418	Preventive Care and Screening: for Clinical Depression and Follow-Up Plan
	1365	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
	N/A	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
	N/A	Dementia: Cognitive Assessment
	N/A	Maternal Depression Screening
Diabetes	0055	Diabetes: Eye Exam
	0056	Diabetes: Foot Exam
	0060	Hemoglobin A1c Test for Pediatric Patients
	0062	Diabetes: Urine Protein Screening
Obesity	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
Cardiovascular Disease	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
	0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
	0083	Heart Failure (HF): Beta- Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
	142	Aspirin Prescribed at Discharge
	435	Discharged on Antithrombotic Therapy
	436	Anticoagulation therapy for atrial fibrillation / flutter
	438	Antithrombotic Therapy By End of Hospital Day 2
	439	Discharged on Statin Medication
	639	Statin Prescribed at Discharge
	N/A	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
Prevention/ Early Intervention	0032	Cervical Cancer Screening
	0033	Chlamydia Screening for Women
	0034	Colorectal Cancer Screening
	0038	Childhood Immunization Status
	0041	Preventive Care and Screening: Influenza Immunization
	0043	Pneumonia Vaccination Status for Older Adults
	387	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
	469	Elective Delivery
	716	Healthy Term Newborn
	N/A	Breast Cancer Screening
	N/A	Children Who Have Dental Decay or Cavities
	N/A	Pregnant patients with HBsAg Testing
	N/A	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
Hosptial and ER Utilization	0002	Appropriate Testing for Children with Pharyngitis
	0036	Use of Appropriate Medications for Asthma
	0069	Appropriate Treatment for Children with Upper Respiratory Infection
Miscellaneous	0022	Use of High-Risk Medications in the Elderly
	419	Documentation of current medication in the medical record
	N/A	HIV/AIDS: Medical Visit

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